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PERFORMANCE AUDIT OF THE HEALTH DEPARTMENT'S ADMINISTRATION OF THE PA HEAD INJURY PROGRAM

June 1991

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*/The acronym PHIP is used frequently throughout this report to refer to the Head Injury Program which has been established by the PA Department of Health under the provisions of Act 1985-45. The program is also sometimes referred to as the Commonwealth Head Injury Program (CHIP). The acronyms EMS, EMSOF, and CMRF are also used in this report. EMS means emergency medical services; EMSOF refers to the special Emergency Medical Services Operating Fund established by Act 1985-45; and CMRF refers to the restricted revenue account within the EMSOF known as the Catastrophic Medical and Rehabilitation Fund.

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I. *INTRODUCTION*

Each year thousands of individuals suffer traumatic brain injury, most frequently from motor vehicle accidents. Injuries of this type may initially result in loss of consciousness and a period of coma. Upon regaining consciousness, head trauma victims are often left with disabilities which prevent their return to a normal home, work and daily living environment.

A recent study by the Pittsburgh Research Institute indicated that each year nearly 16,000 Pennsylvanians suffer head injuries which require hospitalization. The study also determined that Pennsylvania has an annual incidence rate of 6.0 cases of "severe" head injury[1/] per 100,000 population. With a population of approximately 12 million, this translates to an anticipated incidence of 720 severe head injury patients per year. Many of these patients require expensive long-term and even lifetime care. For some patients, the cost of such care exhausts their insurance coverage and all alternative financial resources.

Act 1985-45, as amended, the Emergency Medical Services Act, provides for the establishment of a Catastrophic Medical and Rehabilitation Fund (CMRF) for victims of trauma. The purpose of the CMRF, which is administered by the PA Department of Health, is to make monies available to trauma victims "to purchase medical, rehabilitation, and attendant care services when all alternative financial resources have been exhausted."

In 1988, the Department of Health established the PA Head Injury Program under the CMRF provisions of Act 1985-45, as amended. This program serves as a "payor of last resort" for head trauma victims who have exhausted all of their other financial resources.

In response to concerns which were raised regarding the Department of Health's administration of the Head Injury Program, a resolution calling for an investigation of the program was introduced in the PA House of Representatives in June 1990. Specifically, House Resolution 337 called for an investigation of "the manner in which the Department of Health is administering the Catastrophic Medical and Rehabilitation Fund for victims of trauma."

1/As defined by the PA Department of Health, a head injury is an insult to the brain, not of degenerative or congenital nature, but caused by an external physical force that may produce a diminished or altered state of consciousness, which results in impairment of cognitive abilities or physical functioning. It can also result in the disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustment.

Although this resolution was not passed, the Legislative Budget and Finance Committee was subsequently requested to examine the manner in which the Department was administering the program.

Action was taken by the Committee in response to this request at a public meeting which was held on November 28, 1990. At this meeting, the Legislative Budget and Finance Committee directed its staff to conduct a performance audit of the PA Department of Health's administration of the Emergency Medical Services Operating Fund (EMSOF),2/ with specific attention to be directed to an examination of both the Department's administration of the PA Head Injury Program and state EMSOF funding for statewide emergency medical services development.

This report presents the results of the LB&FC's audit of the PA Head Injury Program. A second report, which will deal with the Department's administration of state funding for emergency medical services, will be completed and released later this year.

Audit Objectives

The PA Department of Health is responsible for administering the state Emergency Medical Services Operating Fund (EMSOF) which was created by the Emergency Medical Services Act (Act 1985-45, as amended). The PA Head Injury Program, which was established under the provisions of Act 1985-45, is funded from the "Catastrophic Medical and Rehabilitation" portion of the EMSOF.

The objectives of this audit were as follows:

1. To test compliance with and evaluate the Department of Health's implementation of the requirement under which the PA Head Injury Program was established (i.e., that 25 percent of the EMSOF be allocated to a "Catastrophic Medical and Rehabilitation Fund" for victims of trauma for the purchase of medical, rehabilitation, and attendant care services when all alternative financial resources have been exhausted).

2. To examine and evaluate the Department of Health's administration and management of the PA Head Injury Program and determine what effects current program operations are having on trauma victims.

2/The Emergency Medical Services Operating Fund is a state special fund created by Act 1985-45 into which monies derived from special emergency medical services fines and fees on certain traffic violations are deposited. The Catastrophic Medical and Rehabilitation Fund, from which the Head Injury Program is funded, is a restricted revenue account within the EMSOF.

3. To determine if monies generated through special emergency medical services (EMS) fines and fees and deposited in the EMSOF are adequate to provide for assistance to trauma victims as required by Act 1985-45 and, in particular, to fund the PA Head Injury Program.

Audit Scope and Methodology

This audit of the PA Head Injury Program established pursuant to Act 1985-45, the Emergency Medical Services Act, focused on the administrative operation and management of the program by the PA Department of Health. A determination and assessment of program results and individual client outcomes were not within the scope of the audit. The time frame covered by the audit was March 1988 (program start-up) through May 1991.

For all audit objectives, pertinent state statutes were examined. Meetings and interviews were also held with pertinent officials and staff of the Pennsylvania Department of Health (DOH) throughout the audit regarding specific issues related to each audit objective.

To evaluate actions taken by the Department of Health to comply with the legal requirement (in Act 45) that the Department provide financial assistance to eligible trauma victims, LB&FC staff obtained information on the establishment and eligibility provisions of the PA Head Injury Program (PHIP) and examined pertinent Commonwealth financial reports and internal DOH records.

Program materials, including the PHIP interim policies and manual, draft regulations and related program files, were also reviewed to identify the types of services being provided, and if the program is set up to operate as a "payor of last resort" (i.e., to provide financial assistance when all alternative financial resources have been exhausted). Examination of fiscal records was undertaken to determine the annual amounts and purposes of expenditures from the Catastrophic Medical and Rehabilitation restricted revenue account (within the state Emergency Medical Services Operating Fund--EMSOF) and if these expenditures were consistent with the intent and specific provisions of Act 45.

To complete the second objective and evaluate the Department's administration and management of the PHIP, LB&FC staff carried out a review and assessment of the structure, staffing and overall operation of the program. The PHIP application and placement process was flowcharted and each step in the process was analyzed. The actual implementation of this process was also compared to program guidelines and requirements set forth in the PHIP interim policies and manual.

In this regard, the adequacy of PHIP management information systems and internal administrative controls was studied, with particular attention directed to the adequacy of the Department's monitorship of the program. Information was compiled from DOH files on the current number of persons being served by the program, the current number and "age" of pending applications, and the amounts expended by the Department since the start of the program (by service provider).

To further evaluate the Department's management of the program, individual PHIP client and service provider files were examined. Testing of these files was conducted to determine current client service priority classifications and if all financial eligibility forms, periodic reports, and other required documentation are being maintained.

To determine what effects current program operations are having on trauma victims, LB&FC staff examined client files and obtained input from PHIP case managers and interested organizations and associations. Specific comments and suggestions in this area were obtained from representatives of the PA Head Trauma Family Network, the Pennsylvania Association of Rehabilitation Facilities, and Schirm Associates and Main Line Rehabilitation Associates, Inc. (two firms that provide rehabilitation services to trauma victims).

To complete the third objective and determine if current funding sources are adequate to provide for trauma victims assistance as required by Act 45, LB&FC staff examined the current annual yield from EMS fines and fees (a portion of which is earmarked for trauma victims assistance) in relation to current actual PHIP costs. LB&FC staff also determined the current balance in the Catastrophic Medical and Rehabilitation restricted revenue account and the number and estimated costs of serving persons for whom applications for admission to the PHIP are currently pending. This information was analyzed in conjunction with recent study estimates of the annual incidence of severe head injury in Pennsylvania and the Act 45 provision which apparently envisioned that financial assistance could be made available to more than one category of trauma victims.

The audit was conducted in accordance with generally accepted government auditing standards. No information has been omitted from this report because it is deemed privileged or confidential.

Report Structure and Acknowledgements

This report consists of four chapters: Chapter I, Introduction, contains information on the origin of the audit, audit objectives, and scope and methodology; Chapter II presents the audit findings and recommendations; Chapter III provides background descriptive information on the PA Head Injury Program; and Chapter IV, Appendices, sets forth various supplemental information.

The LB&FC staff expresses appreciation to the officials and staff of the PA Department of Health who participated in this audit. In addition to Dr. Ronald David, Acting Secretary of the Department of Health, LB&FC staff wish to thank Kum S. Ham, Ph.D, Director of the Department's Division of Emergency Medical Services; Elaine M. Terrell, PHIP Manager; Caroline L. Bowes, EMS Program Specialist; and staff of the Department's Division of Rehabilitation for the cooperation and assistance which they provided.

Also acknowledged is the input and assistance which was received from Frank Martin, President of the PA Head Trauma Family Network; Jan Loeffler Bergen, PA Association of Rehabilitation Facilities; Rita Cola Carroll of Main Line Rehabilitation Associates, Inc.; and Catherine Brownlee of Schirm Associates.

The LB&FC staff involved in this performance audit was under the direction of the LB&FC Executive Director Philip R. Durgin and Chief Analyst John H. Rowe. The audit team leader was Senior Analyst Patricia A. White. Peter L. Halvorsen and Natalie A. Jacoby, Analysts, worked on the audit on a full-time basis and Linda J. Armstrong, Analyst, provided part-time assistance during the audit process. Jonathan P. Nase, Counsel, and Krista L. Keisling, Paralegal, also assisted in the audit effort. Secretarial support was provided by Beverly L. Brown, B. Anne Gange, and Shannon M. Opperman. Additional staff assistance was provided by Michael G. McKenna and Charles V. Saia.

IMPORTANT NOTE

This report contains information developed by the Legislative Budget and Finance Committee staff. The release of this report should not be construed as an indication that members of the LB&FC necessarily concur with all of the information contained in the report. The LB&FC as a body, however, supports the publication of the information and believes it will be of use to the members of the General Assembly by promoting improved understanding of the issues.

Any questions or comments regarding the contents of this report should be directed to Philip R. Durgin, Executive Director, Legislative Budget and Finance Committee, P. O. Box 8737, Harrisburg, Pennsylvania 17105-8737.

II. *AUDIT FINDINGS AND RECOMMENDATIONS*

A. *OVERALL FINDING ON THE ESTABLISHMENT AND OPERATIONAL STATUS OF THE PA HEAD INJURY PROGRAM*

The PA Head Injury Program (PHIP) was initiated by the Department of Health (DOH) in 1988 as a "payor of last resort" for services to individuals who have experienced traumatic brain or head injuries. The establishment of the PHIP is consistent with the trauma victims assistance provisions of Act 1985-45 (the State Emergency Medical Services Act) which make special Emergency Medical Services Operating Fund monies available to trauma victims "to purchase medical, rehabilitation and attendant care services when all alternative financial resources have been exhausted."

As of May 1991, 122 head trauma patients were receiving PHIP financial assistance for institutional, residential rehabilitation and case management services.[1] *Program expenditures for such services during FY 1990-91 are expected to be approximately $3 million.*

Responsibility for administration of the PHIP is assigned to the Department's Division of Emergency Medical Services (DEMS). Beginning in late 1990, the Division took a number of steps to improve the management of the program. Examples of actions taken included the initiation of basic program monitoring activities, the designation of a DEMS staff member as program manager and further refinement of draft regulations for the program. Also, the Division staff recently completed an internal planning report on the "status and future direction" of the PHIP. While some progress has been made and the Department is giving increasing attention to the program, numerous administrative and operational problems remain, and the program appears to be seriously underfunded.

The following are specific observations and conclusions regarding the current operational status of the program:

1. *The program has been operated without regulations since it began in 1988; program operations are governed by interim policies and an internal program manual. Draft regulations currently under review within the Department*

1/The PHIP provides case management and other services for eligible Pennsylvania residents who have sustained a traumatic head injury that results in significant physical, cognitive and/or behavioral impairment. Three distinct services are provided: case management, 24-hour per day structured, supervised living and comprehensive rehabilitation services to a maximum of $125,000 per patient per benefit year. See Section III for further background descriptive information on the PA Head Injury Program.

propose significant changes which would restrict program eligibility. (See Finding B.)

2. *Applications for new admissions to the program are not being processed; 81 applications were pending with the Department as of May 1991, many for six to eight months. For some applicants, the potential exists that they will run out of funding and lose services before DOH processes their application and determines whether they can accept them into the program. (See Finding C.)*

3. *Program records are incomplete and there is a lack of basic information needed for program management, legislative oversight and public information purposes. (See Finding D.)*

4. *The program is being operated on a part-time basis by staff of the Department of Health's Division of Emergency Medical Services; there is no program director and only two staff members are assigned to the program on a part-time basis. (See Finding E.)*

5. *Only a relatively small portion of monies available for trauma victims assistance has been expended and a substantial balance (projected at $10.4 million by the end of FY 1990-91) has accumulated in the special account which funds the PHIP. (See Finding F.)*

6. *Although a substantial balance has accumulated in the special account, the existing PHIP funding source (i.e., Act 45 EMS fines) is not adequate to fully serve the potential target population of head trauma victims. The annual cost of serving the current PHIP caseload of 122 fully consumes the program's annual share of EMS fines. As of May 1991, 81 applications for PHIP services were pending, and additional applications can be expected on an ongoing basis. It is estimated that 720 Pennsylvanians suffer severe head injuries each year, many of whom are potential PHIP clients. (See Finding G.)*

7. *The apparent underfunding of the PHIP is even more pronounced when the potential eligibility of victims of other types of trauma (e.g., spinal, burn) is considered. While head trauma victims have been designated by the Department of Health as having priority for available CMRF funds, other categories of trauma victims may be eligible for financial assistance under the provisions of Act 1985-45. (See Finding G.)*

8. *Public information on the program is inadequate; the Department has not developed a public information brochure or other descriptive materials on the program. (See Finding H.)*

9. *Although the stated objective of the program is to promote independent living within the least restrictive environment, most PHIP expenditures are for long-term institutional care; the program does not currently cover the costs of in-home therapy or community reentry services. (See Finding I.)*

10. *There is no source of outside input and advice on program matters; a PHIP Advisory Committee originally established in 1987 is no longer operational. (See Finding J.)*

11. *Quality assurance standards have not been developed for the program and the Health Department is not adequately monitoring its operation. (See Finding K.)*

12. *Minimum standards and a formal process for selecting and admitting institutional and case management service providers to the program have not been developed. Two current PHIP service providers, facilities in New Hampshire and Texas, have received $1.6 million, or 61 percent of all PHIP expenditures for institutional services since the start of the program. (See Finding L.)*

RECOMMENDATIONS

1. ***Before attempting any further expansion of the PA Head Injury Program, the Department of Health should direct attention to resolving the numerous administrative and operational problems which are present within the program.***

2. ***Given the extent to which problems exist in the program and the lack of a program director and full-time staff to address these problems, the Department of Health should consider convening an internal task force to develop a formal plan of action to structure and fully operationalize the PA Head Injury Program. This task force should seek input and assistance from a reactivated PHIP Advisory Committee which is recommended in Finding J of this report.***

Note: ***Recommendations which address the specific administrative and operational problems cited in this finding are presented in Findings B through L of this report.***

EXHIBIT 1. SERVICE PRIORITY CATEGORIES FOR THE PA HEAD INJURY PROGRAM AND NUMBER OF PATIENTS BY PRIORITY CATEGORY, AS OF FY 1990-91

	Brief Description	Number of Patients FY 1990-91
Priority I	Eligible patients shall be classified by the Department as Priority I if they are considered a threat to themselves or others and require a 24-hour a day structured, supervised living environment in order to gain appropriate behavior control.	19
Priority II	Eligible patients shall be classified by the Department as Priority II if they require comprehensive residential or day rehabilitation services in order to function more independently in the community, but do not meet the criteria specified for Priority I.	15
Priority III	Eligible patients shall be classified by the Department as Priority III if they require ongoing rehabilitation services to maintain an appropriate level of functioning within the community, but do not meet the criteria specified for Priority I and II.	88
Priority IV	Eligible clients shall be classified by the Department as Priority IV if they do not meet criteria for Priorities I, II and III.	0
	Total	122

Source: "Head Injury Program Interim Policies" and related data, PA Department of Health.

B. *REGULATIONS HAVE NOT BEEN PROMULGATED FOR THE PA HEAD INJURY PROGRAM*[1]

Although the PA Head Injury Program was initiated in March 1988, program regulations have not yet been promulgated. In the absence of regulations, the program is being operated on the basis of an internal Department of Health (DOH) program manual and a statement of "interim" program policies. However, draft regulations were under review within the DOH as of May 1991. These regulations propose significant changes which would restrict program eligibility.[2]

DISCUSSION

The PA Head Injury Program was initiated in March 1988. Since that time the Department of Health has operated the program on the basis of an internal program manual and "interim policies." These documents, which were reportedly developed by Health Department staff, provide broad direction to the program, establish service "priority categories," define eligibility criteria, and provide other program guidelines. These documents are not, however, readily available to persons outside the Department.

Although originally drafted in 1989, regulations governing the operation of the PHIP have not yet been promulgated. These original draft regulations were prepared with input from a now defunct PHIP Advisory Committee (see Finding J). Based on LB&FC staff review of program files, it appears that these regulations proceeded through internal review within the Department but were never submitted to the regulatory review process.

A memorandum dated August 28, 1990, from the Department's legal staff to the then PHIP director contained a number of suggested adjustments to the draft regulations and requested further

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1/The Department of Health (DOH) has also not officially prioritized the distribution of funds available to trauma victims from the Emergency Medical Services Operating Fund (EMSOF). The EMS Act provides for a Catastrophic Medical and Rehabilitation Fund (CMRF) from which monies are to be disbursed by the Department to eligible victims of trauma; the act also states that the Department may, by regulation, prioritize the distribution of these funds by classification of traumatic injury. The DOH has not promulgated regulations but rather established funding priority for head trauma victims by publication in the PA Bulletin in March 1988. Financial assistance from the CMRF is, therefore, presently available only to victims of head trauma.
2/See Appendix G for information on selected provisions of the PHIP draft regulations.

review of the regulations. There is no indication that further development of this draft of the regulations was pursued beyond this point.

During the spring of 1991, the Director of the Department's Division of Emergency Medical Services and other Department staff undertook a major revision of these regulations. No outside advisory input was received during the development of this draft of the regulations.

This rewrite of the regulations includes significant changes in the emphasis of the program, including the proposed elimination of patients currently classified as "Priority I" (i.e., patients who are considered a threat to themselves or others) and a three-year limitation on eligibility for program services. As of May 1991, the PHIP regulations were being reviewed by the Department's legal staff. According to the Director of the Division of Emergency Medical Services, no formal timetable has been established for internal finalization and submission of these regulations to the regulatory review process.

In the meantime, an important state program is being operated without benefit of published regulations and many key program decisions (e.g., related to maximum compensation limits and patient service priority categories) appear to have been made by Department staff without input and reaction from interested parties which would be possible if subjected to the regulatory review process. Also, without regulations or public information materials (see Finding H), potential program recipients and other interested parties do not have ready access to published information regarding program services, eligibility criteria, application requirements, and other key aspects of program operation.

RECOMMENDATION

1. ***The Department of Health should expedite its internal review and finalization of the draft regulations for the PHIP. To assist in this process, the Department should seek input and reaction to the current draft regulations from a reactivated PHIP Advisory Committee which is recommended in Finding J of this report.***

C. *APPLICATIONS FOR THE PA HEAD INJURY PROGRAM ARE NOT BEING PROCESSED*

Applications for the PA Head Injury Program are not being processed beyond initial screening, and the program is essentially closed to new admissions. As of May 1991, 81 applications from head trauma victims were on file and awaiting processing by the Health Department. Many of these had been pending for 6-8 months, primarily because of staff shortages and the commitment of all funds available for the program for FY 1990-91. In several cases examined by LB&FC staff, the applicants reported that they had no alternative sources of funds for needed services. For these applicants, the potential exists that they will run out of funding from other sources and lose services before the Health Department processes their application and determines whether they can accept them into the program.

DISCUSSION

The PA Head Injury Program application and placement process begins with the submission of an application packet to the Department of Health's Division of Emergency Medical Services. As outlined on Exhibit 3, the process is then to proceed through application review and eligibility determination by program staff, assigned case managers, and a consulting neuropsychologist. However, as of May 1991, applications were not being processed beyond initial screening by DOH staff.

As of May 1991, 81 applications from head trauma victims were awaiting processing by the Department of Health. As shown below on Exhibit 2, 45 percent of these applications had been pending for six to eight months or more.

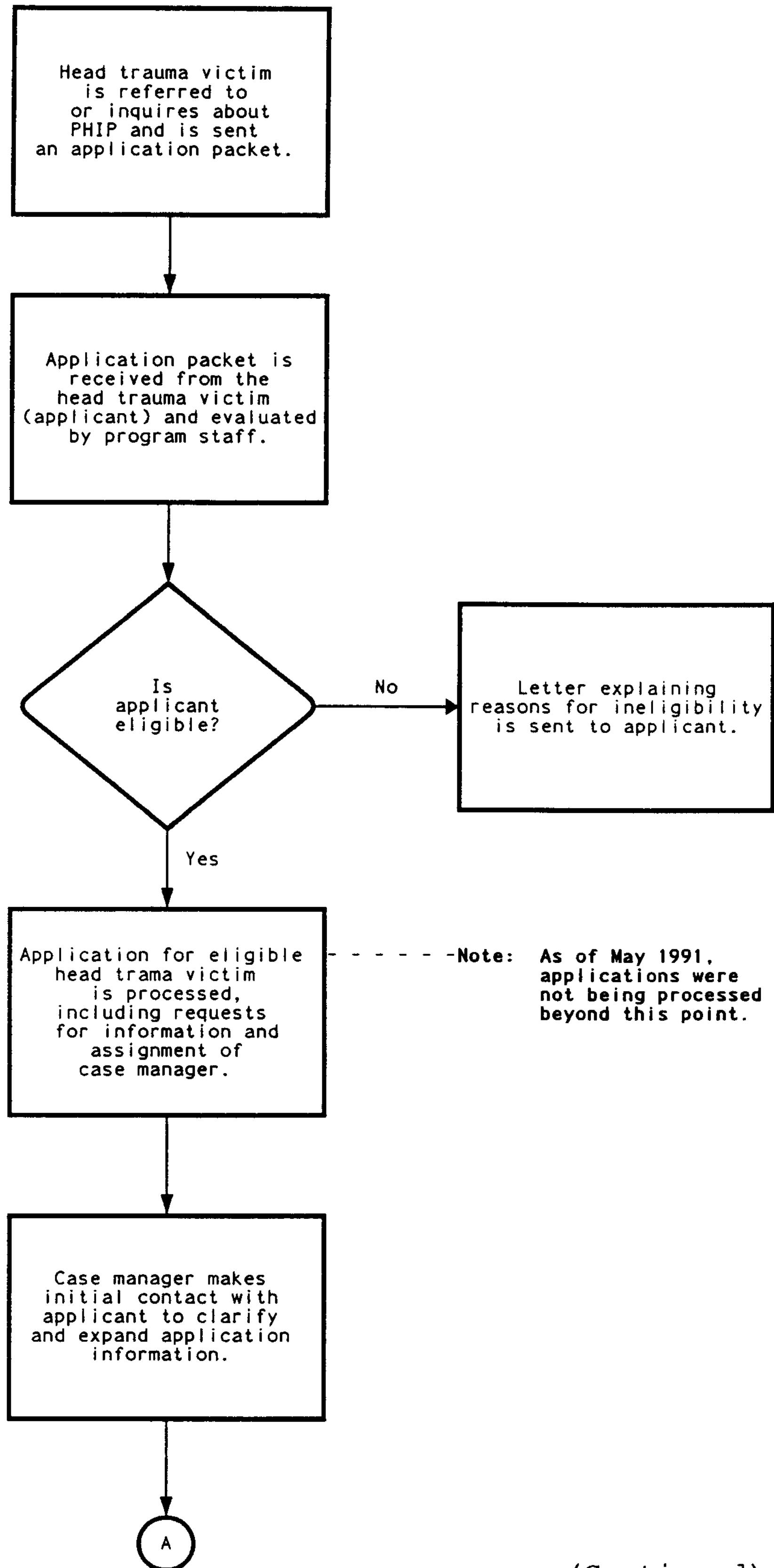
EXHIBIT 2. NUMBER AND AGE OF PENDING APPLICATIONS FOR ADMISSION TO THE PA HEAD INJURY PROGRAM, AS OF MAY 16, 1991

Number of Calendar Days Application Pending[a/]	Number of Applications
0-60	10
61-120	14
121-180	20
181-240	28
241+	8
Total	80[b/]

a/The Department has established an internal goal of processing PHIP applications within 90 days of receipt.
b/Information was not available in the files to determine the number of days that one of the applications was pending.

Source: Developed by LB&FC staff from review of PA Head Injury Program files.

EXHIBIT 3. FLOWCHART OF THE PA HEAD INJURY PROGRAM (PHIP) APPLICATION AND PLACEMENT PROCESS



(Continued)

A

Case manager assesses applicant status to determine completeness of diagnostic review, to assess individual's eligibility and priority status, and to make recommendations to program staff.

Case manager develops case management plan in consultation with involved parties.

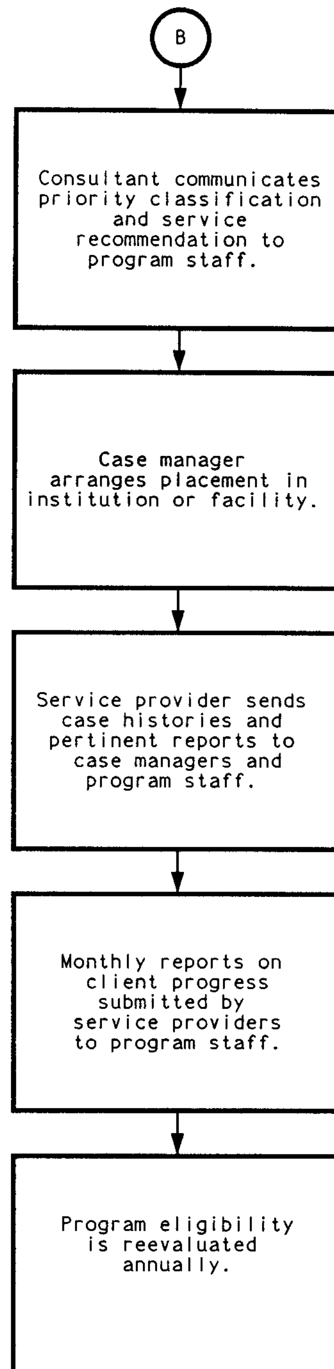
Case manager recommends treatment services to program staff.

Program staff reviews case management recommendation.

Case management recommendation, including supporting documentation, is sent to program consultant for verification and recommendation.

B

(Continued)



<u>Important Note</u>: A complete description of the PHIP application and placement process is shown in Appendix A.

Source: "Head Injury Program Manual" supplemented with information obtained through interviews with Department of Health program staff and review of program files.

LB&FC staff examination of the 81 pending files indicated that the applications had not proceeded past initial review and screening by DOH staff and that patient files were not being assigned to case managers for evaluation and service placement. File review also indicated that the Department has not sent timely written notification to all applicants acknowledging the receipt of their applications and informing them of their status.

LB&FC staff examination of the Department's file of pending PHIP applications indicated that considerable delays have occurred in corresponding with applicants regarding their PHIP applications. Letters were sent by the Department on March 29 and April 1, 1991, to all persons who had applications pending at that time (including some applications which had been submitted as early as July 1990). These letters, which appear to be the first official contact[1/] from Health Department staff since the applications were submitted, stated as follows:

> All available funds have been committed to patients currently enrolled in the program. As current patients move out of our program to other sources of services and funding, we will be able to accept new eligible clients. Please be assured that we will keep your application on file, as well as request the medical records and will contact you for additional information when an opening occurs.

Delays in processing program applications can be attributed to several factors. These include the absence of a formal program management and administrative structure, the lack of adequate staff, the absence of program regulations, and the commitment of all funds appropriated for the PHIP through June 30, 1991. (The Health Department requested and received a PHIP appropriation for FY 1990-91 in the amount of $3.0 million. However, at the time the appropriation was made, the balance in the Catastrophic Medical and Rehabilitation Fund was approximately $8.7 million.)

Act 1985-45 indicates that the ". . . catastrophic fund shall be available to trauma victims to purchase medical, rehabilitation and attendant care services when all alternative financial resources have been exhausted." To ensure that all other financial resources have been exhausted, program applicants are required to complete a "financial resources" statement which is to supply information relative to all other financial resources available to

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1/The exception is a group of 13 applicants who had submitted applications in January and February 1991. This group received a February 2, 1991, letter indicating that they would be notified within 90 days regarding their eligibility for the PHIP. This letter was superseded by the March 29 letters.

them. These include, for example, CAT Fund benefits, Social Security Disability Insurance, Supplemental Security Income, Medicaid, etc. (See Appendix D for a copy of this form.)

This information is to be confirmed by a PHIP case manager during the application review process. LB&FC staff found that none of the pending application files contained this form.[2/] As a result, LB&FC staff relied on information supplied by the applicant (on their application) to determine their apparent financial status at the time of application.

LB&FC staff review of pending application files indicated that some of the applicants were reporting that they have or will soon exhaust all of their financial resources. Of the 81 persons for whom applications were pending, 12 reported that they were not eligible (as of the date of their application) for other funding but that eligibility determinations from other sources were pending.[3/] Eight of these twelve persons were reportedly in rehabilitation facilities at the time of their application. Their continued receipt of services at these facilities was, however, uncertain pending eligibility determination.

One rehabilitation service specialist informed LB&FC staff that during such waiting periods it may be necessary to remove individuals from their current treatment settings which can have an adverse impact on their rehabilitative progress. For example, if the facilities in which the 8 PHIP applicants cited above decide to send these individuals home while waiting for an eligibility decision to be reached, such a decision may adversely affect progress made by these head injury victims.

2/Also, only 6 of the 28 current program participant files contained a completed financial resources form. See Finding K for further information on DOH monitorship of the program.

3/It should be noted that certain of these alternative funding sources would very likely not be adequate to cover the costs of the services required by the PHIP client. In such cases, PHIP monies would then be needed to cover the remaining costs. For example, some PHIP clients receive benefits from the Catastrophic Loss Trust Fund (CAT Fund). However, CAT Fund benefits only provide a partial payment for services. The fund pays only for medical treatment and rehabilitation services exceeding $100,000. In addition, fund recipients generally may only receive up to $50,000 a year with a maximum of $1,000,000 lifetime. Therefore, in some cases, PHIP benefits begin when CAT Fund eligibility expires. A study conducted for the Department of Health by the PA Association of Rehabilitation Facilities indicated that for residential treatment facilities long-term care was estimated, on average, to cost $60,000 to $125,000 a year.

A letter found in the PHIP files clearly illustrates this potential scenario:

> As of _____, Mr. _____ owes _____ $51,732. _____ has continued to work with _____ with the hopes that some funding will become available . . . .
>
> If Mr. _____ does not have any possible funding sources there are few alternatives for placement due to his behavioral dyscontrol. The only option considering the serious gap in funding would be to place him in some type of psychiatric state hospital or nursing care facility where he could be managed most likely through medication management. This medication management would not be rehabilitation therapy, it would be to sedate or control his behavior . . . .
>
> _____ will work to make the best discharge possible if in fact no funding becomes available. There will become a point before the end of February that _____ will have to look at discharging Mr. _____.

Applications for these persons need to be processed in a timely manner because the program is a "payor of last resort" for these trauma victims. While the Department does not have specific information on the current service and funding situations of these applicants, it can be assumed that some could run out of funding from other sources and lose services before the Department processes their application.

RECOMMENDATIONS

1. *The Department of Health, as a routine step in the PHIP application processing system, should send timely written acknowledgment of the receipt of PHIP applications and should periodically inform applicants in writing of the status of their applications.*

2. *The Department should develop a formal waiting list for PHIP services. In developing this list, the Department should attempt to determine the current service and funding situations of all persons for whom PHIP applications are currently pending.*

D. *LACK OF BASIC MANAGEMENT INFORMATION ON THE PA HEAD INJURY PROGRAM*

The Department of Health's (DOH) record-keeping on the PA Head Injury Program (PHIP) has been unstructured and incomplete. The program lacks an established management information system, and no automation of program files has yet occurred. As a result, the DOH does not have important information which is needed to manage and monitor the program, and there is little financial and statistical information available for legislative oversight and public information purposes.[1]

DISCUSSION

The maintenance of basic fiscal information on governmental programs is necessary for program management and accountability purposes. The establishment and maintenance of program management information systems are key elements of an agency's internal controls. As stated by the U.S. General Accounting Office, internal controls are:

> The plan of organization and methods and procedures adopted by management to ensure that resource use is consistent with laws, regulations, and policies; that resources are safeguarded against waste, loss, and misuse; and that reliable data are obtained, maintained, and fairly disclosed in reports. [Emphasis added.]

During this audit, LB&FC staff requested various basic information from the Department of Health on the PA Head Injury Program. For example, among the information requested was a breakdown of program expenditures by fiscal year, number and categories of clients served and service provider; information on total number of persons served by the program since the start of the program and a record of client progress or outcomes; the current balance in the Catastrophic Medical and Rehabilitation Fund; and the number and "age" of pending applications for admission to the program. The Department was generally unable to provide information of this type.

The unavailability of this data can be traced to several factors. First, the Department has not established a management information system for the PHIP. Additionally, program files are unstructured, have not yet been automated, and are not maintained in a central location.

1/See Finding K for specific examples of deficiencies in program monitorship which are related to the absence of basic management information.

To develop information needed for the audit, LB&FC staff worked with program files to compile basic data on program operations and expenditures. Data compiled in this manner was subsequently reviewed and discussed with DOH staff.

The absence of management information on the program appears to result primarily from a failure to define and structure a record-keeping and management information system at the outset of the program. Record-keeping deficiencies also relate, however, to staffing shortages within the Division of Emergency Medical Services.

RECOMMENDATIONS

1. *The DOH should develop an automated PHIP management information system, including established record-keeping requirements and the periodic development of reports on program clients and expenditures for program management and oversight purposes.*

2. *Pertinent program information derived from this management information system should be made available to the General Assembly through the annual reports which are to be produced by the Division of Emergency Medical Services pursuant to Act 1985-45, as amended.*[2]

2/The EMS Act requires the Department to annually publish comprehensive, specific reports of EMS activity and plan implementation.

E. *THE PA HEAD INJURY PROGRAM IS BEING ADMINISTERED BY HEALTH DEPARTMENT STAFF ASSIGNED TO THE PROGRAM ON A PART-TIME BASIS*

As of May 1991, the PA Head Injury Program (PHIP) did not have a director[1/] and all program administrative functions were being carried out by two staff members of the Health Department's Division of Emergency Medical Services (DEMS). These individuals, one of whom has been designated as PHIP manager, split their time between PHIP and emergency medical services program duties.

DISCUSSION

As of May 1991, the PA Head Injury Program was being administered by Health Department staff who are assigned to the program on a part-time basis. Responsibility for administration of the program rests with the Division of Emergency Medical Services (DEMS) within the Bureau of Special Public Health Services.

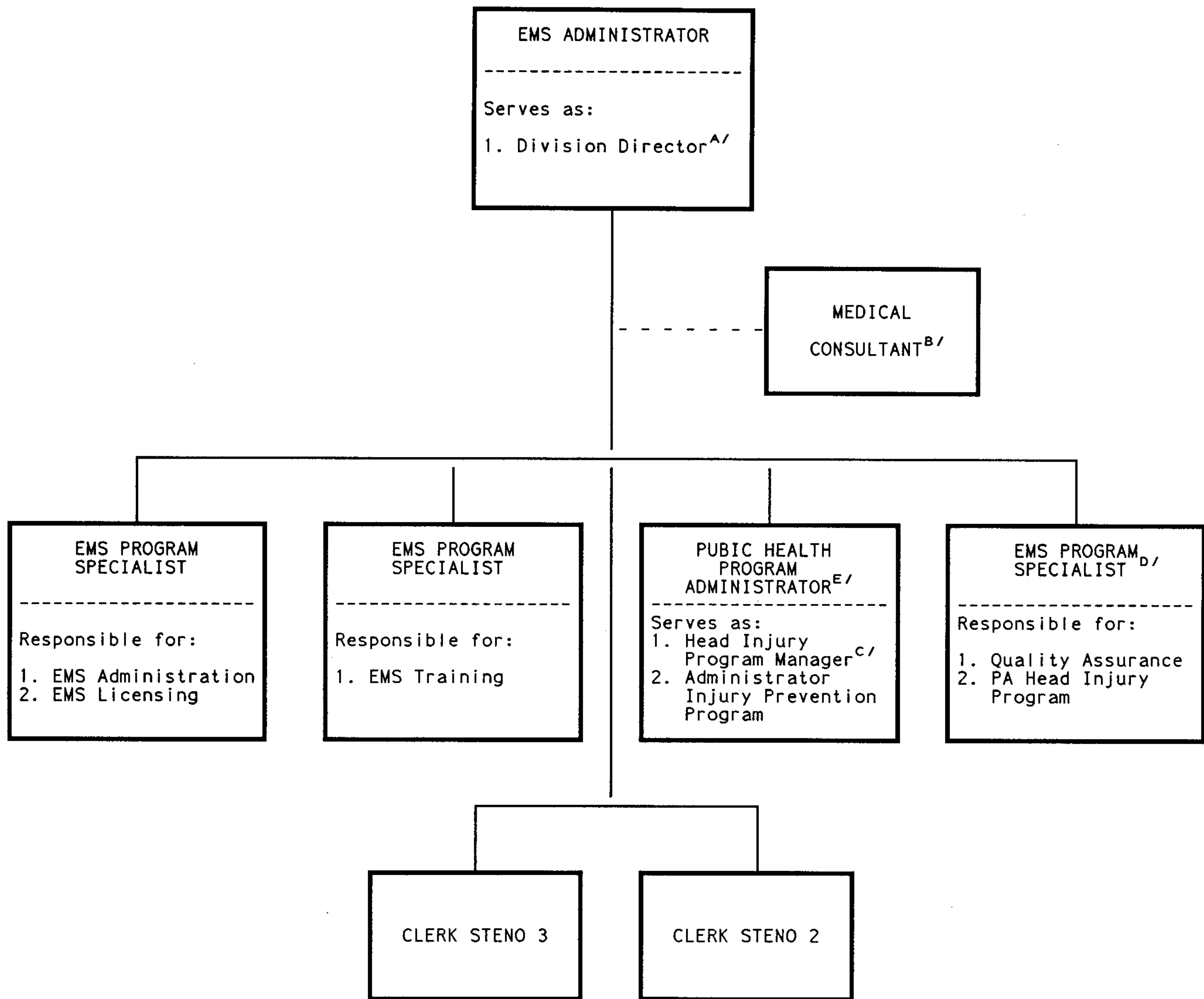
The primary mission of the DEMS is the development and coordination of a statewide emergency medical services system as provided for in Act 1985-45. Among the duties and responsibilities carried out by the Division are the following: (1) statewide EMS planning; (2) ambulance service inspection and licensure; (3) coordination of statewide EMS communications systems; (4) coordination of EMS training and certification of emergency medical technicians (EMTs) and EMT-paramedics; (5) coordination of EMS development through the state's regional EMS councils; and (6) implementing statewide EMS data collection, monitorship and quality assurance programs.

As shown on Exhibit 4, the Division had a staff of seven as of May 1991. This included the Division Director, three EMS Program Specialists, one Public Health Program Administrator, and two clerical positions. The Department's authorized complement is seven. Six of these positions are filled; one position, an EMS Program Specialist, was vacant at the time of the audit. The additional position shown on the DEMS organization chart on the following page (a Public Health Program Administrator) is on loan to the Division from the Bureau of Epidemiology and Disease Prevention.

Responsibility for administration of the PHIP was transferred to the DEMS in July 1990. Prior to its transfer to the DEMS, the PHIP was administered by a full-time program director and one clerical support posicion within the Department's Division of Rehabilitation. The program director was transferred to the DEMS

1/The Director of the Division of Emergency Medical Services reportedly spends 25 percent of his time on PHIP matters.

EXHIBIT 4. ORGANIZATION CHART OF THE DIVISION OF EMERGENCY MEDICAL SERVICES*



*/The Division of Emergency Medical Services is responsible for implementing the statewide EMS system provided for in Act 1985-45 and for administering the PA Head Injury Program (PHIP). Positions shown on this chart were filled as of May 7, 1991. Three positions (two temporary-wage clerk typists and one coordinator for emergency management) were removed from the complement during the course of the audit. a/The Division Director reportedly spends 25 percent of his time on the PHIP. b/The Division does not currently have a medical consultant. A contract with Conemaugh Valley Hospital for medical consultant services was cancelled in February 1991 due to lack of funds. c/This position is reportedly split between PHIP and EMS Injury Prevention duties on a 70/30 percent basis. d/This position is reportedly split between the PHIP and EMS Quality Assurance duties on a 50/50 percent basis. e/This position is reportedly on loan from the Bureau of Epidemiology and Disease Prevention.

Source: Developed by LB&FC staff as of May 1991.

along with the program and subsequently retired from state service in November 1990. (The program director position, a Public Health Executive I, was however retained on the complement of the Department's Division of Rehabilitation.)

As stated in an internal Department document, the decision to transfer the PHIP to the Division of Emergency Medical Services was considered to be appropriate "since survivors of traumatic head injury are the result of the well-established program of support, training, and certification of the emergency medical services system." The position of the PHIP program director was not filled, however, and the addition of another program responsibility to the Division has been problematic.

For many months all program matters were being handled by one EMS program specialist. This individual split her time between regular emergency medical services duties and the PHIP. Recently, an additional member of the DEMS staff was assigned to PHIP and was designated as the manager of the program. Both of these individuals retain duties and responsibilities in the EMS area, however. The program specialist splits her time on a 50/50 percent basis between the PHIP and the EMS quality assurance, while the PHIP manager's time is divided on a 70/30 percent basis between the PHIP and administration of the EMS injury prevention program. (See Exhibit 4.)

In December 1990, the Department's Deputy Secretary for Public Health Programs requested authorization from the Office of Administration to fill the PHIP director position. In this request, the Deputy noted that the DEMS is very short-staffed and that the PHIP is "a highly visible program which needs to be reinforced by better management." The request also indicated that new admissions to the PHIP would have to be discontinued unless staff were authorized.

Because only part-time staff are available to the program, applications for new admissions to the program are being delayed, the program is not being properly monitored, and basic program records are not being maintained. The use of DEMS staff to administer the Head Injury Program is also reportedly having a negative effect on the staff's ability to perform the Division's emergency medical services responsibilities. For example, completion of an EMS quality assurance development plan and a medical command facility implementation process have reportedly been delayed and the development of standardized statewide guidelines for transport of patients by advanced life support personnel have fallen behind schedule.

RECOMMENDATIONS

1. ***The Department of Health should examine possible options which may be available to provide full-time staffing for the PHIP.***

To this end, the Department should seek a legal opinion to determine if monies in the Catastrophic Medical and Rehabilitation restricted account[2/] can be used to hire full-time staff to administer the PHIP.

2. *The Department should also seek legal advice concerning the possibility of using volunteer clerical services which have been offered by the PA Head Trauma Family Network.*

2/The CMRF restricted account within the state Emergency Medical Services Operating Fund is projected to have a balance of $10.4 million as of June 30, 1991.

F. A SUBSTANTIAL BALANCE HAS ACCUMULATED IN THE SPECIAL ACCOUNT WHICH FUNDS THE PA HEAD INJURY PROGRAM

A substantial balance has accumulated in the state special fund which is used to finance the PA Head Injury Program (PHIP). As of June 30, 1990, the balance in the Catastrophic Medical and Rehabilitation Fund[1/] was $8.7 million. As shown on Table 1, this figure is expected to increase to approximately $10.4 million by the end of FY 1990-91. This fund balance results from several factors: (1) while monies were set aside for a trauma victims assistance program since 1985, the PHIP was not established by the Department of Health until FY 1988-89; (2) the Department has requested for appropriation only a relatively small portion of monies available in the special fund; and (3) in the first two years of operation, the Department lapsed more than one-half of the amount appropriated for the Program.

The Director of the Division of Emergency Medical Services informed LB&FC staff that an additional $3.0 million spending authorization may be requested for FY 1991-92 beyond the initial PHIP appropriation request of $3.0 million.

RECOMMENDATION

1. *The Department of Health should provide information to the House and Senate Appropriations Committees and the House Public Welfare and Senate Public Health and Welfare Committees on its immediate and long-term plans for use of the balance in the Catastrophic Medical and Rehabilitation restricted revenue account, including proposed expansion of the PHIP and/or extension of financial assistance to victims of other types of trauma. Such expansion cannot effectively occur, however, until the administrative and operational problems identified in this audit report have been addressed.*

   Important Note: This recommendation should not be interpreted as indicating that unrestricted expansion of the PHIP or extension of assistance to other categories of trauma victims is possible. Although a substantial balance currently exists in the fund, current applicants and the potential target population of future head trauma victims could quickly consume all available funds. (See Finding G.)

1/The PA Head Injury Program is financed from a restricted account in the Commonwealth's Emergency Medical Services Operating Fund (EMSOF). This restricted account, known as the Catastrophic Medical and Rehabilitation Fund (CMRF), receives 25 percent of all monies generated from special traffic fines and fees which are imposed for purposes of implementing Act 1985-45, as amended, the state's Emergency Medical Services Act.

TABLE 1. FINANCIAL STATEMENT OF THE CATASTROPHIC MEDICAL AND REHABILITATION FUND[a/]
FY 1985-86 TO FY 1990-91 (ESTIMATED)

($ Thousands)

	FY 1985-86	FY 1986-87	FY 1987-88	FY 1988-89	FY 1989-90	FY 1990-91 (Estimated)[b/]
Beginning Balance	$ 0[c/]	$ 990	$ 2,524	$ 4,345	$ 5,821	$ 8,719
Receipts:						
Fines/Fees[d/]	981	1,487	1,694	1,923	2,466	2,759[e/]
Interest on Securities	9	47	127	84	296	0
Refunds of Expenditures ...	0	0	0	0	0	0
Prior Year Lapses	0	0	0	0	1,469	667
Total Receipts	$ 990	$ 1,534	$ 1,821	$ 2,007	$ 4,231	$ 3,426
Total Funds Available	$ 990[f/]	$ 2,524	$ 4,345	$ 6,352	$10,052	$12,145
Appropriation	0	0	0	2,000	2,000	3,000
Less Disbursements:						
Expenditures/Commitments ..	$ 0	$ 0	$ 0	$ 531	$ 1,333	$ 1,754
Ending Balance	$ 990	$ 2,524	$ 4,345	$ 5,821	$ 8,719	$10,391

Footnotes to this table appear on the following page.

FOOTNOTES TO TABLE 1

a/The Catastrophic Medical and Rehabilitation Fund (CMRF) is a restricted revenue account within the Emergency Medical Services Operating Fund (EMSOF). The EMSOF was created by "the Emergency Medical Services Act," Act 1985-45.

b/Estimated as of March 31, 1991.

c/The EMSOF funding mechanism (see footnote d) became effective in July 1985.

d/Source of revenues is a special $10 fine levied on certain traffic violations. Act 1988-121 added a $25 fee on persons admitted to programs for Accelerated Rehabilitative Disposition (ARD) related to driving under the influence of drugs and/or alcohol.

e/Total revenues estimated to be received during FY 1990-91 from the special EMS levies described in footnote d above was $11,036,000. These monies are deposited in the special Emergency Medical Services Operating Fund with 25 percent ($2,759,000) going to the CMRF and 75 percent to the EMS account within the EMSOF.

f/The restricted revenue account for the Catastrophic Medical and Rehabilitation Fund (CMRF) was not set up until FY 1986-87. Monies allocated to the CMRF were not separately identified in Commonwealth fiscal reports for FY 1985-86. In FY 1985-86, the amount, $981,000, was combined with the total funds available for EMSOF ($3.960 million) and held in "escrow."

Source: Developed by LB&FC staff from Report of Revenue and Receipts, Special Funds Status of Appropriations Reports and FY 1991-92 Governor's Executive Budget.

G. *EXISTING EMS FUNDING SOURCES ARE NOT ADEQUATE TO FULLY SERVE THE POTENTIAL TARGET POPULATION OF HEAD TRAUMA VICTIMS*

Although additional funds are currently available for appropriation to the PA Head Injury Program (see Finding F), existing funding sources are not adequate to support unrestricted expansion of the program. The annual cost of serving the current PHIP caseload of 122 (approximately $3 million) fully consumes the program's annual share of Act 45 EMS fines. As of May 1991, 81 applications for PHIP services were pending and additional applications can be expected on an ongoing basis. A recent study by the Pittsburgh Research Institute estimated that the annual incidence rate of severe head injury in Pennsylvania is 720 cases. Many of these patients are potential PHIP clients. Additionally, victims of other types of trauma who are also potentially eligible for financial assistance under the provisions of Act 45 are not currently being served.

DISCUSSION

Funding for the PA Head Injury Program is derived entirely from the Catastrophic Medical and Rehabilitation Fund (CMRF). Each year a 25 percent share of fiscal year collections under the Act 45 EMS funding mechanism is deposited in the CMRF. This currently amounts to a deposit of approximately $2.5 to $3.0 million per fiscal year. Unless EMS fines are increased or funding is provided from another source, the annual amount available for trauma victims assistance will remain relatively static.

As shown below, the Head Injury Program will serve 122 patients at a total cost of about $3 million during FY 1990-91.

EXHIBIT 5. BREAKDOWN OF PHIP CLIENTS SERVED DURING FY 1990-91, BY PRIORITY CLASSIFICATION AND ESTIMATED COST

Priority Classification[a/]	Number of Patients	Estimated Annual Per Patient Cost	Total Estimated FY 1990-91 Cost
Priority I	19	$125,000	$2,375,000
Priority II	15	60,000	900,000
Priority III	88	3,000	264,000
Totals	122		$3,539,000[b/]

a/See Exhibit 1 in Finding A for "priority" definitions.
b/Important Note: The actual program expenditures for FY 1990-91 will approximate $3 million because some patients were not admitted until after the fiscal year began.

Source: Developed by LB&FC staff from data obtained from the PA Department of Health, DEMS.

As of May 1991, an additional 81 patients had applied to the program and were awaiting services. Using the estimated annual per patient costs cited in Exhibit 5, LB&FC staff calculated the potential annual costs of providing services to the 81 head trauma victims currently awaiting services. If all 81 were found to be eligible, the annual cost to provide services to this group would be approximately $4.3 million (17 of the 81 applicants requested Priority I funding and 36 requested Priority II status).

For the reasons discussed in Finding F, a substantial balance has accumulated in the CMRF. As of June 30, 1991, the balance in the fund should approximate $10.4 million. While a portion of this balance will be needed to continue services for patients currently enrolled in the program, monies will also be available to meet the service needs of a limited number of new head injury patients. However, although some program expansion may be feasible in the short-term, acceptance of new patients on an ongoing, long-term basis does not appear possible.

A study recently done for the Department of Health by the Pittsburgh Research Institute concluded that Pennsylvania has an incidence rate of 131.7 cases of head injury requiring hospitalization per 100,000 population. Of the 131.7 cases, 99 cases are mild, 26.6 cases are moderate, and 6.0 cases are severe. Therefore, Pennsylvania, with a population of 12 million, can anticipate an incidence of 720 severe head injury patients per year. Many of the individuals within this group may be potential PHIP clients. According to the Health Department, many of the head injury patients in the severe category will require extensive long-term lifetime care.[1/]

Also, it should be recognized that the Act 45 provision for assistance to trauma victims is broad, providing for assistance to victims of trauma when all alternative financial resources have been exhausted. Currently, only one category of trauma victims, head injury patients, is being served.

Applications continue to be received by the Department of Health and officials believe that a "funding crisis" is inevitable unless steps are taken to refocus the program and institute cost-containment measures. To do this, draft PHIP regulations under development at the time of the audit included provisions which would remove Priority I patients, the most expensive to serve, from program eligibility and would terminate coverage for other patients after a three-year period (see Finding B).

1/Cost data developed by the National Head Injury Foundation estimated total lifetime care costs for a person with a severe head injury at $4.6 million (1988 dollars). (See Appendix H.)

RECOMMENDATIONS

1. *The Department of Health should develop formal estimates of the annual and long-term costs of providing services to PHIP clients and the maximum number of head trauma victims which can reasonably be expected to be served by the program given the existing level of funding available from EMS fines. These estimates should be taken into account in defining the program funding priority and eligibility provisions of the PHIP draft regulations which are currently under review.*

2. *The Department should also determine how much of the current balance in the Catastrophic Medical and Rehabilitation Fund (CMRF) is needed to maintain services for current PHIP clients and how much is available to provide services to new clients.*

3. *The Department should also develop an estimate of the potential costs of extending assistance to victims of other categories of trauma as was apparently envisioned in Act 1985-45.*

4. *Information on the estimates recommended above and options for the use of the current CMRF balance should be provided to the House and Senate Appropriations Committees and the House Health and Welfare and Senate Public Health and Welfare Committees.*

H. *PUBLIC INFORMATION ON THE PA HEAD INJURY PROGRAM IS INADEQUATE*

The Department of Health has not developed a public information brochure or other materials to describe and publicize the availability of the PA Head Injury Program. Without formal public information efforts, representatives of the medical, rehabilitation, and emergency medical services communities, as well as members of the general public, may be unaware of the program.

DISCUSSION

The PA Head Injury Program (PHIP) was established by the Department of Health in March 1988. At that time, the initiation of the program was announced by public notice in the Pennsylvania Bulletin. To date, the Department has not developed a public information brochure on the program or otherwise taken steps to formally publicize the program.

The absence of public information on the PHIP was among a list of concerns regarding the program which was developed in May 1990 by the PA Head Trauma Family Network. At that time, the Network stated that "there has been a failure to publicize the availability of the program so that those eligible and in need can take advantage of it."

Also, several members of the PA Emergency Health Services Council who responded to an LB&FC audit questionnaire indicated a lack of awareness of the program. One respondent stated, "I have never received a single piece of information regarding this service despite the fact that I work at a trauma center and am active on statewide EMS agency committees."

Health Department staff assigned to the program acknowledged that public information materials have not been developed. This individual noted, however, that she believes that most rehabilitation centers, hospitals, and case managers are aware of the program and are able to refer patients to the Department. She also noted that the Head Trauma Family Network has publicized the availability of PHIP services in its newsletter.

RECOMMENDATION

1. ***Following adoption of program regulations, the Department of Health should prepare an informational brochure on the PA Head Injury Program. This brochure should present basic information on the program including, for example, available services, eligibility requirements, and application procedures. The Department should make this brochure available to hospitals, rehabilitation centers, state and regional emergency medical services officials, and other interested parties.***

I. PA HEAD INJURY PROGRAM DOES NOT CURRENTLY COVER COSTS OF IN-HOME THERAPY OR COMMUNITY REENTRY SERVICES

Although the stated objective of the PA Head Injury Program is to assist individuals reach their maximum ability to live independently within the least restrictive environment, the vast majority of current program expenditures are for long-term institutional care. A representative of the Head Trauma Family Network and others expressed concerns to LB&FC staff regarding the current "medical model" orientation of the program. While institutional care is necessary for many head trauma victims, patients who could benefit from less costly in-home "facilitator" care and community reentry services are not currently being served by the program.

DISCUSSION

The stated purpose of the PA Head Injury Program (PHIP) is to assist eligible individuals to reach their maximum ability to live independently within the least restrictive environment. However, as currently administered by the Department of Health, PHIP-funded services do not appear to be consistent with the purpose statement for the program.

As provided for in the PHIP interim policies and program manual, eligible services are currently restricted to 24-hour structured, supervised, institutional living arrangements, comprehensive residential rehabilitation settings, and case management services. The Department of Health (DOH) pays for these services, up to a maximum of $125,000 per benefit year for eligible program clients.

Most PHIP expenditures are for long-term institutional and comprehensive rehabilitation services. As shown on Table 2, $1.6 million, or 83 percent of total FY 1990-91 spending through April 1991 went for such services.

TABLE 2. BREAKDOWN OF FY 1990-91 PA HEAD INJURY PROGRAM EXPENDITURES (THROUGH APRIL 1991)

Institutional/Comprehensive Rehabilitation Services ...	$1,641,584
Research - Pittsburgh Research Institute[a/]	234,572
Case Management Services	90,156
Consultant - Drexel University[b/]	1,075
Total (Through April 1991)	$1,967,387

a/A research study on the incidence of head injury in PA.
b/A contract under which professional consultant services are provided by a University neuropsychologist.

Source: Developed by LB&FC staff from information provided by DOH staff and a review of PHIP Participating Provider Agreement files.

TABLE 3. FY 1990-91 PA HEAD INJURY PROGRAM EXPENDITURES BY SERVICE PROVIDER AND CLIENT PRIORITIZATION, AS OF APRIL 1991

Provider/Facility	Priority I[a]		Priority II[a]		Facility Total[b]	
	Expenditures	Number of Patients	Expenditures	Number of Patients	Expenditures	Number of Patients
Highwatch Rehab Center	$ 672,314	10	$108,095	2	$ 780,410	12
ReMed Recovery Care Centers	257,647	5	15,500	2	273,147	7
New Medico Center of Philadelphia	116,075	3	86,450	1	202,525	4
Acadia, Inc.	23,900	2	101,210	2	125,110	4
Beechwood Center	8,234	1	75,736	2	83,970	3
Tangram Rehab Network, Inc.	81,135	1	0	0	81,135	1
Pegasus Integrated Living Center	0	0	51,400	1	51,400	1
Moss Rehabilitation Hospital	0	0	26,080	1	26,080	1
United Cerebral Palsy of Central PA	15,300	1	0	0	15,300	1
United Cerebral Palsy of Pittsburgh	0	0	2,507	1	2,507	1
Totals	$1,174,605	23	$466,978	12	$1,641,584	35

a/The number of patients within each priority classification is as reported by DOH program staff and does not necessarily match the classification of program clients indicated on service provider invoices.
b/Figures shown were obtained from the "Contract Budget Liquidation Sheets" which were in the DOH's Participating Provider Agreement files as of April 1991. Expenditure figures represent the total of invoices received and approved for payment by the Department of Health as of April 1991.

Source: Developed by LB&FC staff from information contained in Department of Health files.

A breakdown of the $1.6 million which was spent for institutional and comprehensive rehabilitation services through April 1991 is shown on Table 3. On this table, expenditures are shown by PHIP priority service category and provider facility. As shown, $1.2 million or about 72 percent of this amount was for Priority I patients (i.e., those who are considered a threat to themselves or others and who require a 24-hour a day structured, supervised living environment).

The current orientation of the program toward institutional care was apparently established by DOH staff who were involved in the initial design and start-up of the program. Also, the emphasis of the PHIP is, to some degree, reportedly similar to a state-operated head injury program in Massachusetts.

During the audit a number of persons expressed concerns to LB&FC staff regarding the current institutional orientation of the PHIP. For example, in May 1990, the Head Trauma Family Network noted the following as a "point of frustration" regarding the program: "There is no funding available to provide attendant (facilitator) care in the home for those families attempting to care for a traumatically brain damaged person in the community."

This concern was reiterated to LB&FC staff by the President of the Head Trauma Family Network in April 1991. This individual expressed the belief that many head trauma victims who are currently institutionalized could be cared for at home if financial assistance were made available for attendant care or facilitator services to assist family members to care for the victim.

A similar point of view was expressed by an official of the PA Association of Rehabilitation Facilities. This individual expressed the opinion that too much emphasis has been placed on Priority I patients and not enough on treating patients in their homes. She also expressed the opinion that in-home care is the least expensive and can be one of the most effective for a head injured individual at an appropriate point in the rehabilitation process. Most patients, in her opinion, do not need to be placed in expensive long-term care facilities and could function in their home if they had a facilitator or other trained person coming in to work with them on a regular basis. This individual indicated that, while a member of the PHIP advisory committee, a proposal was made by the committee that PHIP funds be used for in-home respite care.

Finally, a representative of a firm that provides rehabilitation services to head trauma victims expressed the opinion that it is important to return head trauma victims to their communities as soon as possible and not maintain them in institutions or nursing homes when such care is not necessary.

At the time of the audit, PHIP monies were not being expended for in-home attendant care (also referred to as facilitator care) or community reentry services. Such services may involve independent living skill training, daily living support, and supportive employment.

One rehabilitation provider defines community reentry services as follows:

> A comprehensive outpatient service to reintegrate skilled behaviors, provide training in basic and advanced community skills, and retrain to integrate skills into routines and programs of daily life. Daily life routines include self care; housekeeping; leisure activity; work adjustment; personal business, and finances; consumer activities and community affairs. Attention is given to mental processes such as memory, attention, verbal and spatial processing, organization, planning and judgment. Services are provided by professions of occupational therapy, reading psychology, vocational therapy, neuropsychology, psychiatry, and life skill coaching.

Such services can be provided through facility-based programs, apartment programs and through in-home facilitators or community reentry specialists. One rehabilitation specialist with whom LB&FC staff spoke reported that researchers have shown in recent years that the most effective way to promote successful community reentry is to provide services in the client's natural and permanent environment. According to this individual, national head injury groups are currently lobbying for programs to be more focused on this type of treatment.

The costs of in-home care and community reentry services may be less than institutional and comprehensive rehabilitation settings. While LB&FC staff did not conduct extensive cost comparison work, rates for community reentry services were obtained for two rehabilitation providers.

In one case the daily rates of community reentry services in the client's home is reported to be $120; in another case the daily rate was reported to be $325. This compares to daily rates currently being paid for institutional-based services in the $200 to $500 range.[1/]

1/In some cases, institutional-based service costs exceed $500 per day. However, the Department has reportedly established a per diem cap of $500 for services provided to PHIP clients. This cap does not, however, appear in the program manual, interim policies, or in the draft regulations currently being developed by the Department.

The Director of the Division of Emergency Medical Services indicated that the Department is attempting to change the focus of the PHIP. Draft regulations recently developed by the Department would phase Priority I clients out of the program and limit program eligibility for other clients to three years. The draft regulations also state that "rehabilitation services are designed to be part of the continuum of treatment with the goal of supporting an individual functioning in the community." However, the draft regulations stop short of providing for in-home facilitator care as an allowable program service.

Specifically, the draft regulations state that the purpose of PHIP services is:

> to assist eligible clients in maintaining or sustaining themselves within their home, community or stable destination of their choice. The setting is expected to be available to the client on a consistent basis through the support of their family or other social support services.

PHIP services allowable under the draft regulations would be limited to (1) independent living services designed to assist the client in maintaining himself within the home, community or a stable designation of his choice or (2) full-time (24-hour) or day rehabilitation services to assist the client to obtain activities of daily living, social, cognitive, or behavior skills so as to maintain or sustain himself within his home, community or stable designation of his choice.

RECOMMENDATIONS

1. ***Consistent with the stated purpose of the PHIP, the Department of Health should consider revising current draft regulations to specifically define community reentry and in-home facilitator care as eligible services under the program.***

2. ***The Department of Health should identify providers within Pennsylvania who are qualified to provide community reentry and in-home facilitator care and who would be interested in participating in the PHIP. The Department should notify interested providers of the procedure to follow to become eligible to serve PHIP clients and should seek to make such services available through the program beginning in FY 1991-92.***

J. *HEAD INJURY PROGRAM ADVISORY COMMITTEE IS NOT OPERATIONAL*

A Head Injury Program Advisory Committee established by the Health Department in mid-1987 is no longer operational. This committee, which was convened by the Secretary of Health to assist in "redefining the priorities and services to be offered" through the Head Injury Program, has not met since December 1989. Several persons involved in head trauma victim care and advocacy expressed concerns to LB&FC staff regarding the absence of an active advisory committee. The Director of the Division of Emergency Medical Services indicated that the committee will be reactivated once regulations for the program are in place.

DISCUSSION

In mid-1987, the Department of Health convened a 12-member Head Injury Advisory Committee to assist in the initiation of the Head Injury Program. In addition to staff of the Departments of Health and Labor and Industry, this committee included representatives from the Hospital Association of Pennsylvania, the Pennsylvania Trauma Systems Foundation, the PA Association of Rehabilitation Facilities, United Cerebral Palsy, Head Trauma Family Network, head injury medical specialists, and legislative staff.

This advisory committee was assembled by the Secretary of Health to assist in "redefining the priorities and services to be offered." The committee met periodically from 1987 through December 1989 but has not met since that time. The specific role which the advisory committee played in the development of the PHIP is unclear as no meeting minutes or written record of advisory committee recommendations were available from the Department of Health. Department officials indicate, however, that the advisory committee had involvement and input in the development of initial draft regulations for the program.

As discussed in Finding B, the regulations for the PHIP have recently been rewritten by Health Department staff. This version of the program regulations provides for the Department to have authority to appoint a 15-member advisory committee representing the interests of providers, family members, head injury patients, care givers, service providers, and other members of the support system. Such a committee had not been appointed as of May 1991. The Director of the Division of Emergency Medical Services reported that this committee will be appointed after regulations for the program have been finalized and promulgated.

RECOMMENDATIONS

1. ***The Department of Health should reactivate the PHIP advisory committee. Given the current status of the program, the***

Department should consider reactivating the committee as soon as possible (rather than waiting until program regulations are finalized) so that advice and assistance can be obtained to address the numerous operational and administrative problems identified in this report. The Department should also consider obtaining input and reaction from this advisory committee to the recently revised PHIP draft regulations.

2. *In reestablishing the advisory committee, the Department should consult with interested organizations such as the Head Trauma Family Network to ensure that adequate family member representation is provided for on the committee. The Department should also consider including at least one head injury survivor on the committee.*

K. *HEALTH DEPARTMENT MONITORSHIP OF THE PA HEAD INJURY PROGRAM IS INADEQUATE*

The Department of Health (DOH) has not developed quality assurance standards for the PA Head Injury Program (PHIP) and is not adequately monitoring its operation. Examples of specific deficiencies noted during the audit include incomplete client and provider files, lack of fiscal monitorship (e.g., related to provider invoicing and payment, third-party payors and maximum compensation limits), and failure to assess the quality and appropriateness of program services and overall program effectiveness. These deficiencies are directly related to an overall lack of program structure and organization and the unavailability of adequate staff to administer the program. As a result, there is an absence of quality assurance and accountability in the program. Recently developed draft PHIP regulations state that the Department will identify the "necessary components" for a statewide PHIP quality assurance program.

DISCUSSION

LB&FC staff examination of PA Head Injury Program files indicated numerous deficiencies in basic program oversight and management. Specific deficiencies noted are briefly discussed below:

1. The Department is not maintaining complete PHIP client files:

   - With one exception, individual case management plans[1/] for PHIP clients are not in DOH files.

   - Required monthly patient case management reports from provider facilities and case managers are missing from many files.

   - Forms entitled "Head Injury Program Statement of Understanding" which outline services to be provided and terms and conditions of the program and which are to be signed by the client, the client's parent or guardian, and case manager are generally not in the DOH files. (Such forms were found in only 4 of 28 files examined.) (See Appendix C for a copy of this form.)

1/A PHIP case management plan is to specify the following: the recipient's needs or problems; the goals established to assist in the resolution of the needs or problems; the activities required to reach the desired goals; the organizations or individuals responsible for the activities; and provide an analysis of the financial responsibility to be borne by the recipient, the program or any other party involved. (See Appendix B for a copy of the case management plan format.)

- PHIP Financial Resources Statements are generally not in DOH files. These are needed to certify that PHIP clients have exhausted all of their alternative financial resources and that the PHIP is the "payor of last resort." (Such forms were found in only six of 28 files examined.) (See Appendix D for a copy of this form.)

2. The Department has not maintained a master listing of PHIP clients against which invoices from providers can be checked. As of spring 1991, actions were being taken to develop such information.

3. The Department does not maintain current listings of institutional service providers and case managers who have valid provider service agreements.

4. The Department has not formally assessed the quality and appropriateness of services provided to PHIP clients. Although some facilities were apparently visited by the prior program director, there is no written record of his observations regarding the facilities and their programs. Several facilities which have valid provider agreements are located out-of-state, i.e., in New Hampshire and Texas.

5. The Department is not systematically reviewing case management reports prepared by providers and/or case managers on the status of patients in PHIP.

   - Such review is necessary to ensure that the reports contain all information called for in the "Head Injury Program Manual."

   - Review of provider reports could also serve as a monitoring tool for the Department to cross-check reported services for individual clients against services billed on provider invoices.

6. The Department is not conducting annual reevaluations of PHIP client eligibility as is required by the "Head Injury Program Manual."

7. Although there are indications that corrective action is now being taken, the Department was not requiring that invoices from case managers for services rendered to PHIP clients include the names[2] of individual PHIP clients for whom services were being charged.

2/In at least some recent cases, DOH staff have required case managers to indicate client names and client contact sheets for individuals receiving services during the billing period.

8. The Department does not have a means to measure the effectiveness of the program in meeting established program objectives (e.g., by tracking and measuring patient progress or outcome in achieving goals established in their case management plan).

9. The Department does not have a formal mechanism in place to track annual payments made on behalf of individual PHIP clients to determine if maximum program reimbursement levels are reached ($125,000 per benefit year) and if payments for case management services are to be included in this limit. While PHIP documents appear to indicate that case management payments should be included, they were not being included at the time of the audit.

10. The Department does not have a system in place to ensure that billings submitted to the Department have been adjusted for payments made to PHIP providers from third-party payors, e.g., SSI, veterans benefits, CAT Fund, family members. (There is apparently some confusion as to whether this responsibility rests with the Department, the provider or the case manager.) At the time of the audit, the Department was working with one provider to resolve an overpayment of approximately $143,000.

11. The Department has not established a procedure to notify providers and case managers when they have received $25,000[3/] in PHIP payments and, therefore, are required to have an independent audit conducted and submit the results to the Department.[4/] Presently, there is a lack of fiscal accountability in the program.

12. The Department does not have a precise, reliable breakdown of current program clients, by priority classification (PHIP clients are classified as Priority I, II, III, or IV).

    - The priority classification of individual PHIP patients sometimes differs between program file documents and invoices.[5/]

3/Prior to June 1990, the audit threshold was $100,000.
4/As of May 1991, no audits had been conducted of the PHIP by either the Comptroller's Office or the Office of the Auditor General.
5/This discrepancy could pose additional problems for the Department if proposed regulations which would eliminate Priority I clients from the program are adopted.

- According to the PHIP Program Manual, classification of eligible patients into one of four priority service categories is to be done by the Department at the time of initial eligibility determination. This does not consistently occur. Contact with case managers indicate that case managers are sometimes making this determination.

- The prioritization or classification of patients is unclear and does not appear to be fully understood by individuals involved in the program, and case managers have not received definitive guidelines for classification. According to a representative of a group of companies that provide specialized services for head trauma patients, "there is no defined process or criteria [in the PHIP] for making objective determinations as to who falls under these classifications and, even more importantly, who is likely to derive significant benefit from services."

- Documentation does not exist in DOH files to explain cases in which the Department has overruled the eligibility/priority classification/service recommendations of its expert consultant.

RECOMMENDATION

1. ***The Department of Health should take corrective actions to address the specific program monitoring deficiencies identified in this finding. The Department should also develop quality assurance standards and a formal service and fiscal monitoring system for the program.***

L. *ABSENCE OF MINIMUM STANDARDS AND A FORMAL PROCESS FOR PROVIDER SELECTION/ADMISSION TO THE PA HEAD INJURY PROGRAM*

The Department of Health does not have a formal process through which service providers are selected for participation in the PA Head Injury Program. Written selection criteria and minimum qualifications and standards for PHIP case managers and institutional service providers do not exist in the PHIP program manual, interim policies or in regulations recently drafted for the program. No specific documentation is available from the Department concerning the basis upon which current PHIP case managers and institutional facility operators were selected. Two out-of-state facilities, located in New Hampshire and Texas, have received 61 percent of all institutional service expenditures made since the start of the PHIP.

DISCUSSION

Operation of the PA Head Injury Program (PHIP) is predicated upon the delivery of services to program clients by contracted case managers and institutional service providers. No formal process exists, however, for provider application, selection, and admission to the program.

As of May 1991 the Department of Health had entered into agreements with 15 institutional facility operators and at least 27 entities providing case management services as part of the Head Injury Program. During FY 1990-91, nearly $3 million will be paid to these providers for services rendered to PHIP clients. (Listings of these current service providers are contained in Appendix E and Appendix F.)

There is no record of the manner in which the Department initially notified the potential provider community of the possibility of participating in the PHIP. There is also no documentation of the basis upon which the current program providers and case managers were selected. The DOH employee who previously served as the PHIP director and who was reportedly involved in provider selection has retired, and there is no written record of the selection process.

INSTITUTIONAL SERVICE PROVIDERS

As of May 1991, the Department of Health had entered into written PHIP provider service agreements with 15 institutional service providers. (One additional agreement was pending.) These include 13 hospitals and special rehabilitation facilities and programs in Pennsylvania, one facility in New Hampshire and one in Texas. At that time, 10 of the 15 providers with current agreements were receiving reimbursement for services provided to PHIP clients. (See Table 4.)

No written standards or criteria for PHIP institutional service providers have been established. The selection of the current institutional service providers appears to have been based, at least in part, on "letters of interest" submitted by the providers to the Health Department.

There are also indications in DOH files that on-site visits to certain facilities were made as part of the provider selection process. In some cases, the former PHIP director apparently visited facilities and explained the program to facility operators. However, current PHIP staff were not aware of any written documentation on the results of these visits or of criteria or standards which were applied in this initial solicitation and selection of institutional providers.

A Health Department attorney familiar with the PHIP indicated that his input was not requested during the initial contracting period and that no established minimum qualifications or standards exist with respect to the institutional service providers.

LB&FC staff also observed that $1.6 million, or 61 percent of all PHIP expenditures made for institutional services since the start of the program, have gone to out-of-state facilities in Center Ossipee, New Hampshire, and San Marcos, Texas. (See Table 4.) As with the other facilities currently being used, there is no information in DOH files which indicates the reasons these particular facilities and locations were selected for PHIP clients.

Current program staff initially indicated that the out-of-state facilities were chosen because they could serve Priority I PHIP clients (i.e., those who are considered a threat to themselves or others and require 24-hour structured, supervised living environments) and because there were no facilities in Pennsylvania which could serve this patient type.

However, DOH contract files list several Pennsylvania facilities that report the availability of Priority I type services. Further, as of May 1991, about one-half of the PHIP clients classified as Priority I were receiving services in facilities located in Pennsylvania. Placement in distant locations would appear to be inconvenient for the patient's family and results in out-of-state expenditure of state revenues which could potentially be paid to Pennsylvania firms and workers.

Also illustrative of deficiencies in the provider selection process is a case example involving a group of companies which has been attempting to become a participating PHIP service provider. A representative of this group, which provides intensive residential transitional living programs in Pennsylvania, Maryland and Massachusetts, contacted LB&FC staff to express concerns regarding the time required to process provider agreements. LB&FC staff were

informed that this particular group provided a completed Participating Provider Agreement to the Health Department in September 1990, again provided the Department with a copy of the original agreement in November 1990 because the first one had been lost and was then told in January 1991 that the program was closed to new service providers. A copy of the unsigned agreement was found by LB&FC staff during a review of the provider agreement files.

CASE MANAGERS

Case management services are provided to eligible PHIP clients "to assist them and their families assess their needs for successful living and plan and advocate for the services needed to fulfill these needs." Case managers are assigned by the Department of Health to individual PHIP clients and are responsible for the following:

- An assessment of alternative financial resources available to the client.

- Performance or recommendation of an assessment of physical, cognitive, behavioral or social status required to confirm priority classification or necessary for the development of a case management plan.

- The development of an individualized case management plan.

- Assistance and advocacy for the client or his or her family in obtaining the services outlined in the case management plan.

According to the "PHIP Manual," case management services include the development of a diagnostic review which is to include medical and neurological issues, health and nutrition, sensorimotor capacity including gross and fine motor strength and control, sensation balance, joint range of motion, mobility and function, cognitive capacity, and other matters which would indicate the need for certain minimum education, training and experience qualifications.

As of May 1991, the Department had entered into 27 Participating Provider Agreements for case management services. For a variety of reasons, however, it is not possible to determine the exact number of case managers currently providing services under these agreements (e.g., not all individuals who are providing case management services are listed as approved case managers on the provider agreements and some persons appear to be providing services under more than one agreement). Through April of FY 1990-91, approximately $90,000 had been expended for case management services.

The Department has not formally established minimum qualifications and standards for PHIP case managers. LB&FC staff review of the Participating Provider Agreement files for the case managers who currently have agreements with the Department indicate that some attempts were made by the prior PHIP Director to ensure that case managers selected for the program had certain qualifications. For example, a letter in some case management files indicated that:

> . . . case management services will be at the rate of $20 per hour for individuals who have a nursing diploma and CRRN or others who have a bachelor's degree. We propose to pay $24 per hour for individuals with a master's degree in a helping profession . . . . In addition to the basic education we will require a minimum of one year experience serving individuals who have experienced a head injury, and knowledge of services and facilities available in the geographic area of practice.

DOH files indicate that verification checks were made for some persons who desired to serve as a case manager; however, such information was not present in the files for all current case managers.

Also, a standard fee schedule has not been established for PHIP case management services, and case managers are reimbursed at varying rates. For example, file correspondence lists reimbursement rates in the $20 to $30 per hour range, with consultant case managers with advanced degrees reimbursed at $40 and $50 per hour.

Basic accountability in public programs requires that there be specific selection criteria and minimum qualifications and standards for service providers authorized to receive reimbursement through governmental programs. The Management Directive on <u>Contracting For Services</u> indicates the following:

> Public contracting should represent the model of justifications for the capitalist economic system in that it is open to all. Therefore, to the greatest extent possible, the procedures contained in this manual are intended to enhance those procurement practices and strategies to assure openness for all to participate. . . .
>
> Fair and open competition is a basic tenet of public procurement. Such competition reduces the opportunity for favoritism and inspires public confidence that contracts are awarded equitably and economically. . . .

Information of the basis of contractor selection is also necessary. The absence of such criteria and standards creates the potential for substandard services and impropriety, or the possible appearance thereof, in the selection of authorized providers.

Draft regulations currently being developed for the PHIP do include a section on "provider qualifications." The draft regulations state in part as follows:

1. Providers must be able to provide 24-hour comprehensive, residential services. Accredited licensed facilities and providers will be utilized whenever practicable.

2. The Department shall identify the minimum qualifications for the selection of providers on a biennial basis. Each facility and case manager shall apply to the Department for selection as a provider under HIP.

Also, although not contained in the program policies or manual or in the draft regulations, program staff are currently requesting that potential case managers have a bachelors degree and at least one year of experience in dealing with head injured individuals.

Currently, rehabilitation facilities serving head trauma patients are not subject to specific state oversight or licensure for this specialty care service. Certain of the present providers (9 of 13) are, nevertheless, licensed by the Department of Public Welfare as Personal Care Boarding Homes.[1/]

A report issued by the Pennsylvania Association of Rehabilitation Facilities in September 1990 recommended that "licensing regulations should be developed for head injury post-acute residential programs by state government in cooperation with providers, consumers, and other agencies to ensure health, safety, and welfare as well as appropriate programming."

RECOMMENDATIONS

1. The Department of Health should establish minimum qualifications and specific standards and selection criteria for PHIP service providers and case managers. These should be specified in the PHIP regulations which are currently being developed by the Department. In establishing these standards and

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1/Personal care boarding homes are defined as "a premise in which food, shelter, personal assistance or supervision are provided for a period exceeding 24-consecutive hours for more than three adults who are not relatives of the operator and who require assistance or supervision in matters as dressing, bathing, diet or medication prescribed for self-administration but do not require hospitalization or care in a skilled nursing or intermediate care facility," 55 Pa. Code §2620.3.

criteria, the Department should consider the appropriateness of incorporating relevant provisions of the "Standards Manual for Organizations Serving People With Disabilities" by the Commission on Accreditation of Rehabilitation Facilities.

2. *The Department of Health should develop a formal process through which interested service providers and case managers can express interest in participating in the PHIP. This process should involve the use of a standardized application packet and include the submission to the Department of specific information needed to document the applicant's experience, credentials and overall qualifications for providing PHIP services. This provider application process should be published in the PA Bulletin and should conform to pertinent provisions of the "Contracting for Services" Management Directive 215.1 as amended. Also, the Department should consider obtaining input from the Head Injury Advisory Committee (see Finding J) in the application review and provider selection process.*

3. *The Department of Health should also maintain written documentation of the basis upon which program providers and case managers were selected for participation in the program, including the specific reasons for any placements made to facilities outside of Pennsylvania.*

4. *The Department should establish and publish a standard fee schedule for PHIP case management services.*

5. *The Department should also maintain a current directory listing of institutional service providers and case managers determined by the Department to be qualified and eligible to provide services to PHIP clients.*

TABLE 4. AMOUNTS PAID TO INSTITUTIONAL SERVICE PROVIDERS FOR PA HEAD INJURY PROGRAM PATIENTS, FY 1988-89 THROUGH FY 1990-91 (THROUGH APRIL 1991)

Fiscal Year	Provider/Facility	Location	PHIP Patients Served a/	Amount Paid
1988-89	Highwatch Rehab Center	New Hampshire	5	$116,711
	Beechwood Center	Langhorne, PA	1	18,000
	FY 1988-89 Total			$134,711
1989-90	Highwatch Rehab Center	New Hampshire	8	575,258
	Acadia, Inc.	Lancaster, PA	1	46,870
	Pegasus Integrated Living Center	Erie, PA	1	17,000
	ReMed Recovery Care Centers	Jenkintown, PA	1	62,200
	Tangram Rehab Network, Inc.	Texas	1	4,857
	New Medico Center of Philadelphia	Lafayette Hill, PA	2	52,075
	Beechwood Center	Langhorne, PA	2	31,883
	FY 1989-90 Total			$790,143
1990-91	Pegasus Integrated Living Center	Erie, PA	1	$ 51,400
	ReMed Recovery Care Centers	Jenkintown, PA	7	273,147
	Tangram Rehab Network, Inc.	Texas	1	81,135
	United Cerebral Palsy of Pittsburgh District	Pittsburgh, PA	1	2,507
	United Cerebral Palsy of Central PA	Belleville, PA	1	15,300
	New Medico Center of Philadelphia	Lafayette Hill, PA	4	202,525
	Moss Rehabilitation Hospital	Philadelphia, PA	1	26,080
	Beechwood Center	Langhorne, PA	3	83,970
	Acadia, Inc.	Lancaster, PA	4	125,110
	Highwatch Rehab Center	New Hampshire	12	780,410
	FY 1990-91 Total (Through April 1991)			$1,641,584

a/Does not represent an unduplicated patient count since patients may move between Institutions during a given fiscal year.

Source: Developed by LB&FC staff from PA Department of Health's Participating Provider Agreement files, Contract Budget Liquidation Sheets, as of April 30, 1991.

III. BACKGROUND DESCRIPTIVE INFORMATION ABOUT THE PENNSYLVANIA HEAD INJURY PROGRAM

Legal Background

The Pennsylvania Head Injury Program (PHIP) was established by the Pennsylvania Department of Health during FY 1988-89. The Program was created under the provisions of Act 1985-45, as amended, the Emergency Medical Services Act.

The EMS Act designated the Department of Health as the lead agency for emergency medical services in the state. In this role, the Department is to plan, guide, assist and coordinate the development of areawide medical services systems into a unified statewide system. The Act also provides for a special Emergency Medical Services Operating Fund (EMSOF) consisting of revenues generated from additional fines and fees imposed on certain traffic violations. The Department of Health is responsible for administering this special fund to further the statewide EMS system provided for in Act 45.

Created within the EMSOF is a Catastrophic Medical and Rehabilitation Fund for victims of trauma. According to the Act, 35 P.S. §6934(e), 25 percent of the EMSOF shall be allocated to trauma victims. The distribution of these funds may be prioritized by the Health Department by classification of traumatic injury.

Program Purpose

Act 1985-45 created a Catastrophic Medical and Rehabilitation Fund (CMRF) for victims of trauma. As stated in the Act, the purpose of the CMRF is to make funds available to trauma victims "to purchase medical, rehabilitation and attendant care services when all alternative financial resources have been exhausted."

The Health Department is authorized by the Act to prioritize the distribution of funds by classification of traumatic injury. The Department has prioritized head trauma as the sole priority for CMRF funding.

According to the former Director of the Health Department's Division of Rehabilitation, the establishment of this program put Pennsylvania "in the vanguard of states planning service systems and delivering services to individuals who have experienced traumatic brain or head injuries." This individual also indicated that the Program meets a growing public health concern presented by survivors of serious head injuries who formerly would not have lived. The Program also serves as a "payor of last resort" for trauma victims who have exhausted all of their other financial resources.

Program Services and Eligibility

According to Health Department materials, the Head Injury Program was initially planned to provide case management and other services for eligible Pennsylvania residents who have sustained a traumatic head injury that results in significant physical, cognitive and/or behavioral impairment.

The Head Injury Program provides, through contract, three distinct services:

1. Case management services to assist clients and their families to identify their needs, then plan and advocate for the attainment of the required services.

2. For individuals who, because of organic brain damage, are a threat to themselves and others, the Department will purchase a 24-hour-per-day structured, supervised living environment for up to $125,000 a year from a variety of head injury rehabilitation facilities.

3. For individuals who must improve their daily living, cognitive or behavioral skills to enable them to successfully live in the community, the Department will purchase comprehensive residential rehabilitation services up to $125,000 a year.

As stated in the Department's "Head Injury Program Manual," eligibility criteria for the program include but are not limited to the following:

- Commonwealth residents who have sustained a traumatic head injury on or after July 3, 1985, which results in physical, cognitive and/or behavioral impairment and for whom all alternative financial resources have been exhausted.

- The patient would be reasonably expected to benefit from the service, as determined in the sole discretion of the Department.

The Department considers patients ineligible for services if they are:

- Patients with cognitive or motor dysfunction related to congenital or hereditary birth defects.

- Patients suffering putative birth trauma and/or asphyxia neonatorum (hypoxic-ischemic-encephalopathy).

- Patients with pre-existing organic or degenerative brain disorders.

- Patients suffering from cerebral vascular accidents (CVA).

Program Clients

As of May 1991 the PHIP was serving 122 head trauma patients. A total of 19 of these were "Priority I" patients who are considered "a threat to themselves or others and require a 24 hour a day structured, specialized living environment." (See Exhibit A in Finding A for a description of the PHIP four priority patient classification system.)

Data compiled by the DOH in 1990 indicates that more than two-thirds of the patients being served had been injured as the result of a motor vehicle accident (see below).

EXHIBIT 6. HEAD INJURY PROGRAM APPLICANTS, BY CAUSE OF INJURY (APRIL 1988 THROUGH APRIL 1990)

Cause	Percent
Motor Vehicle-Driver	35%
Motor Vehicle - Pedestrian	13
Motorcycle	13
Bicycle	8
Motor Vehicle - Passengers	7
Sports	5
Assault	5
Falls	4
Moped	3
Industrial/Work	3
Suicide Attempt	3
Other	1

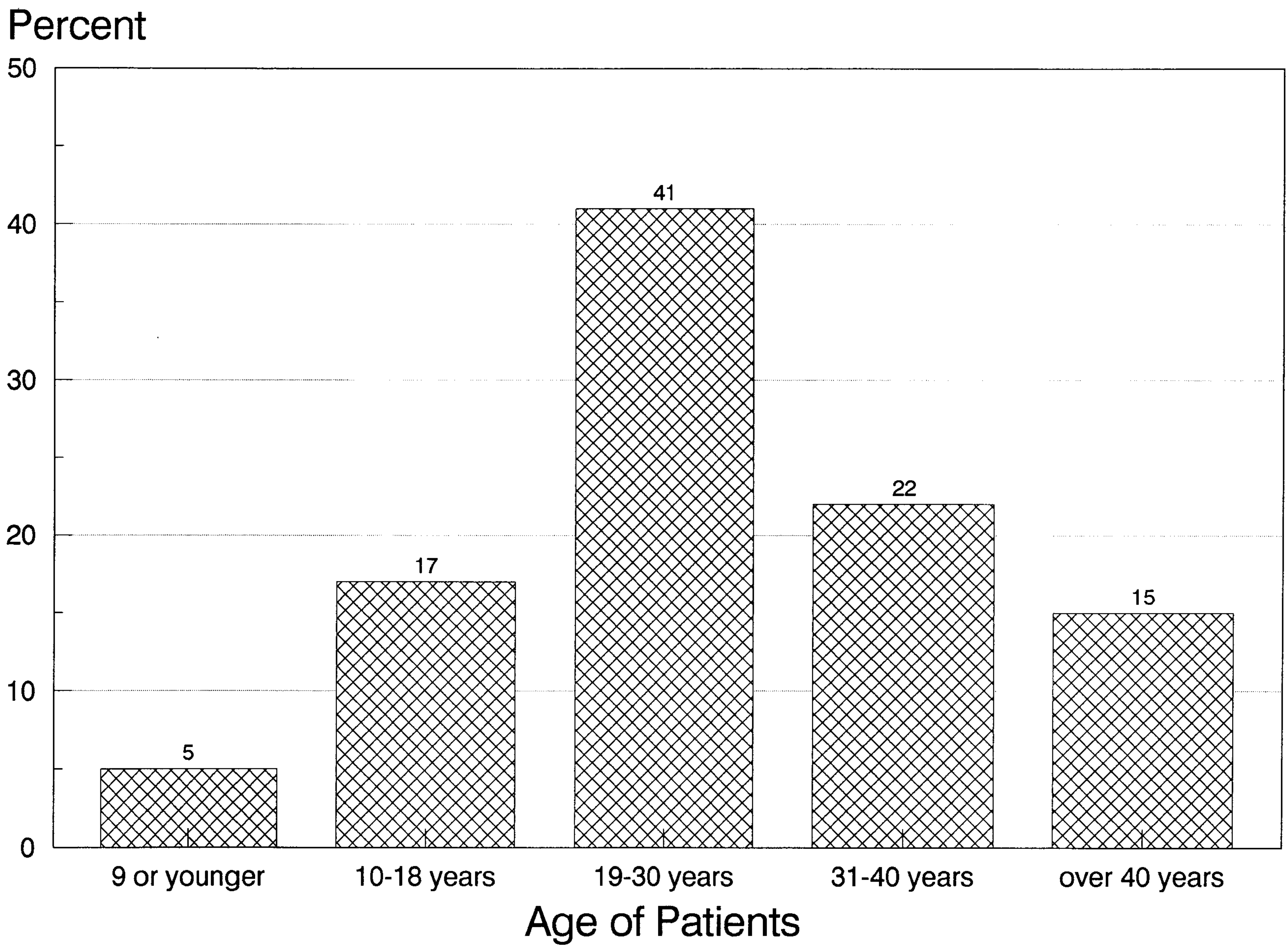
Source: Health Reporter, PA Department of Health, Volume 11, No. 2, April - June 1990.

Program Administration

In its role as EMS lead agency for the Commonwealth, the Department of Health is responsible for administering the Emergency Medical Services Operating Fund. Administrative responsibility for the EMSOF rests with the Department's Division of Emergency Medical Services (DEMS). In addition to administering the 75 percent EMS portion of the EMSOF, the Division is also responsible for administering the 25 percent CMRF portion which funds the PHIP. This latter function was transferred to the Division from the Department's Division of Rehabilitation in July 1990.

The DEMS is organizationally located within the Bureau of Special Public Health Services and is under the jurisdiction of the Deputy Secretary for Public Health Programs. As of May 1991 the DEMS had a staff of seven, including the Division Director,

EXHIBIT 7. AGE OF CURRENT PHIP CLIENTS AT TIME OF INJURY



Source: PA Department of Health, Division of Emergency Medical Services.

three EMS Program Specialists, one Public Health Program Administrator, and two clerical positions.

The PHIP does not have a program director or full-time staff. To administer the program, the DEMS Director has assigned two DEMS staff members to PHIP duties on a part-time basis. One of these individuals has been designated as PHIP Manager. Additionally, the Division Director reports that he spends approximately 25 percent of his time on PHIP matters.

Program Funding and Expenditures

As discussed earlier in this section, the PHIP is financed from the Catastrophic Medical and Rehabilitation restricted revenue account within the Emergency Medical Services Operating Fund. Monies deposited in the EMSOF are derived from a $10 fine on all traffic violations exclusive of parking offenses and a fee of $25 imposed upon persons admitted to programs for Accelerated Rehabilitation Disposition for offenses enumerated in 75 Pa.C.S. §3731, which relates to driving under the influence of alcohol or a controlled substance. These fines are in addition to other fines imposed at the discretion of the court.

Twenty-five percent of the revenues collected from these sources are deposited in the CMRF. Since FY 1985-86, a total of approximately $11 million has been deposited in the CMRF from this source. Interest which accrues on these funds remains in the CMRF.

As shown below, funds were first expended from the CMRF in FY 1988-89.

TABLE 5. PHIP APPROPRIATIONS, EXPENDITURES, AND LAPSES, FY 1988-89 TO FY 1990-91 (AVAILABLE)
($ Thousands)

FY	Appropriation	Expenditures	Lapses
1988-89	$2,000	$ 531	$1,469
1989-90	2,000	1,333	667
1990-91 (Available) ..	3,000	1,754[a]	--

a/As of March 31, 1991.

Source: Developed by LB&FC staff from "Report of Revenues and Receipts," PA Department of Revenue and "Special Funds Status of Appropriations Reports," Office of the Budget.

Program expenditures are made from the CMRF for direct purchase services (including the purchase of residential care or sheltered care services) and case management services for head trauma victims.

IV. APPENDICES

APPENDIX A. OVERVIEW DESCRIPTION OF THE PA HEAD INJURY PROGRAM (PHIP) APPLICATION AND PLACEMENT PROCESS*

A. *Initial Referral/Inquiry to the Department of Health*

1. A head trauma victim is referred to the Pennsylvania Head Injury Program (PHIP) from an outside source (e.g., from a hospital, social worker, case manager, or the Head Trauma Family Network).

2. Individuals interested in receiving program services are provided an application packet by the Department of Health or referring organizations. Included in the packet are a cover letter, program guidelines, application form, and four authorization for release of information forms.

B. Initial Screening by the Department of Health - Returned application forms are to be evaluated by the PHIP Program Director. (Because there is no program director, this function is currently being performed by staff of the Division of Emergency Medical Services.[1/])

- Those applicants who do not meet the Pennsylvania residence requirement, whose injury occurred prior to July 3, 1985, or who had a diagnosis other than head injury are advised by letter of their ineligibility and the reason for the decision. A copy of the Guidelines is attached to the letter with the eligibility provision noted.[2/]

- Those applicants who meet the requirements proceed as described in C below.

C. Processing of Applications for Eligible Applicants - If the applicant meets the basic eligibility requirements, the following actions are to be taken:

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*/IMPORTANT NOTE: This exhibit represents an overview description of the application/placement process as developed by LB&FC staff from the Health Department's "Head Injury Program Manual" and discussions with DOH staff assigned to the program. It should be noted that not all steps in this process necessarily occur in each case and that, as of May 1991, the process was not being carried out beyond the initial screening phase (Part B).

(Continued)

1. Authorization for request of information is sent to the hospital to which the individual was initially admitted on the date of his/her injury to confirm the date and nature of injury.

2. If Priority I or II classification is requested, authorization for request of information is sent to the applicant's current provider. This is necessary to obtain information to assist the Department in making a determination of the validity of the Priority I or II classification.

3. If applicant has recently attended school or is or had been in a special education class, an authorization for release of information is sent to the school to obtain information from the permanent and supplemental education records regarding educational attainment and attendance, and physical and psychological tests.

4. Authorization for release of information is sent to other service provider(s) regarding treatment plans and outcomes.

5. If the applicant appears to meet all eligibility requirements and has indicated a desire to receive case management services, a case manager is selected and a referral initiated.[37] ***(Note: Selection and assignment of case managers was not occurring as of May 1991. Consequently, the remaining steps in the process were not being carried out for eligible applicants.)***

6. Once the materials are received from the hospitals and other institutions to which requests for information forms were sent, the information is to be reviewed by DOH staff assigned to PHIP to determine that all required documentation has been submitted before being forwarded to the case manager. Once reviewed, the information is forwarded to the case manager assigned to evaluate the applicant.

D. *Case Manager Makes Initial Contact* - The case manager interviews the recipient of services and, if appropriate, their family members or guardian at their residence. Application information is clarified and expanded (including financial data), releases signed, initial evaluation of need conducted, referrals made, and information provided regarding the program's services and the recipient's role. Recipient and case manager determine if there is reason to initiate case management services, and recipient (or representative) signs a "Statement of Understanding."

At this time, the case manager is to review the current functioning of the recipient in such areas as self care, housekeeping, work, personal events, and other measures.

(Continued)

E. *Case Manager Assesses Recipient's Current Status* - The case manager reviews the completeness of diagnostic and evaluative information available regarding the recipient's past history and current status. Additional testing may be purchased by the program if necessary and approved.

The purpose of this comprehensive diagnostic review is to assess an applicant's eligibility and priority status, make recommendations to the Department, and begin the development of a case management plan. The diagnostic review, as appropriate, is to include a wide range of factors including, for example, medical and neurological issues, cognitive, perceptual and communicative capacity, behavior, self-care, and interpersonal and social skills.

F. *Case Manager Develops Case Management Plan* - At this point in the process, a case management plan is to be developed in consultation with assessor, providers of services, family members and the recipients. According to the Department, an important aspect in the development of the case management plan is the ability of the case manager to plan creatively in an advocacy mode with these individuals.

The case management plan is to state the specific needs of the recipient, goals to be achieved, providers of service, expected time frames for achievement of each goal, and, if appropriate, identifies potential payors (i.e., other than the CMRF). The plan is to be revised annually or sooner if considered appropriate by the case management team or Department staff. The "Head Injury Program Manual" states that the primary focus of goals should be "movement towards or maintenance of the highest level of functioning."

G. *Case Manager Recommendation to the Department of Health* - If the case manager determines that treatment services from an approved provider facility[47] are necessary, a recommendation for placement of the applicant is made to DOH. The case management plan, along with any recommendation for placement is sent by the case manager to the DOH for review.

H. *Health Department Review of Case Manager Recommendation* - Staff assigned to the PHIP review the information received from the case manager to determine that all case management requirements mandated by the "Head Injury Program Manual" have been performed satisfactorily. This individual is also to review the case manager's recommendation for placement at a particular facility and the reasons that led the case manager to make that determination for placement.

(Continued)

I. *Transmittal of Case Manager's Recommendation to the Health Department's Consulting Neuropsychologist* - Once DOH staff are satisfied that all case management information is complete, they forward the patient's completed application, the case management plan, the information received from the hospitals and other institutions that previously treated the client, and any other pertinent information to the Department's consulting neuropsychologist at Drexel University[5/] for review and confirmation.

The consulting neuropsychologist reviews all materials relevant to the head injury client's current physical and mental condition and makes a recommendation. The recommendation may be to follow the case management plan as prepared by the case manager, or a recommendation for alternative services may be made. The recommendation of the neuropsychologist is then communicated to the Department of Health in a letter.

J. *Consulting Neuropsychologist Communicates Priority Classification/Service Recommendation to the Health Department* - The DOH reviews the neuropsychologist's recommendation and may or may not adopt it. If the recommendation is that the Department purchase services, the Department is to evaluate the need and cost of the requested service against the priority classification of the applicant, the services currently purchased by the Department and available to the client and independent consultation of the appropriateness of the service requested. In most cases, the recommendation is consistent with the recommendation made by the case manager in the case management plan and it is adopted by the Department.[6/]

If the DOH concurs that placement of the head injured client in an approved provider facility is the most appropriate option, the client's case manager is notified.

K. *Case Manager Arranges Placement in an Approved Institution/Facility* - The case manager works with the facility to arrange placement and treatment services. Once a head injured client is placed with an approved provider, reimbursement may be requested by that institution, at least on a monthly basis, for the services that are provided in accordance with the established written specifications that are included in the contract drawn up between the Department and the provider. The cost for services provided may not exceed $125,000 a year for any one individual.

L. *Case Histories and Patient Reports Are to Be Sent to the Health Department* - While a PHIP client is in residence at a provider's facility, regular case histories on the client's progress are to be prepared and forwarded monthly to the DOH and the client's case manager by the facility.

(Continued)

In addition to the above report, the client's case manager is responsible for submitting a report to the Department on each client assigned to them with their monthly invoice. This report is to contain information that addresses the assessments, diagnostic tests, and plans produced during the reporting period. In addition, case management activity during the reporting period and planned activity during the next two months are to be reported to the Department. These reports are maintained in the client's file at the Department.

M. *Patient Eligibility is Reevaluated* - At the end of the benefit year (the date services were initially purchased plus 365 days), the eligibility of a client is to be reevaluated. Services could terminate if alternative financial resources become available or the client becomes eligible for similar services from another provider. Payment for services will also terminate if the patient exceeds $125,000 in allowable program expenses during the benefit year.

(Continued)

Footnotes to Appendix A

1/As of May 1991, two staff of the DEMS were assigned to the PHIP on a part-time basis.
2/Applications can be reconsidered if the applicant can provide additional information supporting their claim.
3/Case managers must have a valid fee for service agreement with the Department of Health in order to be assigned to work with PHIP clients. In making case manager assignments, several factors are taken into consideration. For example, if a case manager has been working with the applicant, most likely he or she will be assigned case management responsibilities for the patient while in the PHIP (providing they have a valid agreement with DOH). Also, if the applicant's relatives request a particular case manager and that case manager has a valid participating contract with the DOH, he or she will be assigned to work with the client. Finally, an applicant will generally be assigned to a case manager who works in the part of the state in which the patient resides.
4/As of April 1991, there were 15 institutions approved for participation in PHIP. These institutions were approved in 1989, the year in which monies were first made available. Such approval was reportedly granted after the institution provided a letter of interest explaining why they should be admitted. The Department will then initiate a "Participating Providers Agreement" with that institution. This agreement sets forth the terms and conditions that the institution must meet if they wish to participate in PHIP and what types of treatment services are reimbursable for a particular PHIP client. If other services are provided, the facility may not seek reimbursement from the DOH for such services. Facilities were approved at the onset of the program for one and a half years. At the present time, the Department is not admitting additional institutions to the program.
5/The DOH has a $30,000 contract with Drexel University, Department of Psychology, Sociology, and Anthropology, under which consulting services are received from one of its resident neuropsychologists.
6/LB&FC staff reviewed 28 PHIP patient files in order to determine whether or not the DOH adopted the consulting neuropsychologist's recommendation. In some cases, the recommendation was not accepted by DOH and the applicant was reclassified. (See Finding K.)

Source: Developed by LB&FC staff from "Head Injury Program Manual," PA Department of Health, February 1990, and discussions with Health Department staff.

APPENDIX B. PA HEAD INJURY PROGRAM CASE MANAGEMENT PLAN

Compiled By ______

Date Compiled ______

Date to be Revised ______

Name ______

Address ______

SS No. ______

DOB ______

Address ______

Current Residence ______

Contact ______

Address ______

Relationship ______

ASSESSMENTS, PLANS	DATE	BY WHOM	LOCATION OR ATTACHED

TEAM MEMBER	TITLE	ORGANIZATION

Strengths ______

I have been involved in the development of this Case Management Plan and agree with the goals and overall direction of the Plan.

Participant ______ Date ______

(Continued)

NO.	CLIENT'S NEEDS	ACTIVITY	OBJECTIVES-OUTCOMES	PROVIDER - INDIVIDUAL OR AGENCY	FUNDING
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					

APPENDIX C. PA HEAD INJURY PROGRAM STATEMENT OF UNDERSTANDING

The Department of Health Head Injury Program will provide advice, counseling and other services as described in your individualized case management plan. The extent to which such services can be rendered is dependent upon the Program's fund balance.

Your assigned case manager will provide the following specific services.

- The case manager will arrange for any evaluation needed to assess your priority status for the program and identify the services you will require for rehabilitation and care.

- The case manager will endeavor to help you understand the extent of your injury and resultant disability, and define the gains expected from therapies that are recommended.

- The case manager will assist you and your family in identifying the utilizing of all services and financial resources that you may be entitled to as a consequence of your injury.

- The case manager will act as your advocate in obtaining services deemed necessary or desirable.

The Department will require your assistance in reaching these goals. Specifically, you will be required to give written authorization for agencies or persons involved in your care to provide the Department with pertinent information about your health status and financial resources. Such authorization will allow the Department or your case manager to discuss your injury and care with the health care providers and insurers. Further, a representative of the Department may engage in conferences or meetings held to review your case.

You will be expected to play an active role in planning, maintaining appointments and following through with mutually agreeable information. You have a right to grieve any decision, including the assignment of a particular case manager. Your grievance should be addressed, in writing, to the Department's program director.

Additional information about the program or services you are entitled to may be obtained from your case manager. You may also contact the Department directly at the above address and telephone number.

Your signature below attests to your understanding of the aforementioned terms and conditions.

Case Manager	Date	Client	Date
		Guardian/Parent	Date

APPENDIX D. PA HEAD INJURY PROGRAM FINANCIAL RESOURCES STATEMENT

I declare the following information regarding benefits, income and assets that have or may in the future be made available to ____________________ as a result of a head injury experienced on ____________________ is true, correct and complete. I authorized any insurance carrier, third-party payor or service provider having knowledge to furnish to the Pennsylvania Department of Health any and all information regarding the benefits, income, assets and services received as a result of the injury.

	ELIGIBLE	PENDING	AMOUNT OR TYPE	ID NUMBER
Private Medical/Hospitalization				
Major Medical				
Medicare				
Medicaid				
Supplemental Security Income				
Social Security Disability				
Catastrophic Loss Trust Fund				
No Fault				
Veteran				
Financial Settlement				
Award from Civil Suit				
Worker's Rehabilitation				
Vocational Rehabilitation				
Victim's Compensation				
Mental Health				
Mental Retardation				
Special Education				
Other				
Additional Information				

I agree to pay ____________________ to ____________________ for care received by ____________________ from income or assets identified above.

____
Signature of Applicant Date
(Required if age 18 or over and not under a court-appointed guardianship.)

____
Signature of Parent/Spouse Date
(Required if applicant is under age 18, but encouraged with applicant consent, regardless of age.)

____
Signature of Legal Guardian Date
(Required, if applicable.)

APPENDIX E. INSTITUTIONAL SERVICE PROVIDERS WITH A CURRENT PENNSYLVANIA HEAD INJURY PROGRAM PARTICIPATING PROVIDER AGREEMENT WITH THE DEPARTMENT OF HEALTH

Provider	Location	Duration of Current Agreement
Acadia, Inc	Lancaster, PA	January 1, 1991 to December 31, 1991
Beechwood Center	Langhorne, PA	July 1, 1990 to June 30, 1992
Bryn Mawr Rehab Hospital	Malvern, PA	September 1, 1990 to December 31, 1991
The Devereux Foundation	Devon, PA	July 1, 1990 to December 31, 1991
Hartefeld Genesis Head Injury Program	Avondale, PA	March 1, 1990 to December 31, 1991
Highwatch Rehab. Center	Center Ossipee, NH	July 1, 1990 to December 30, 1991
Moss Rehab. Hospital	Philadelphia, PA	September 1, 1990 to August 31, 1991
New Medico Center of Philadelphia	Lafayette Hill, PA	April 1, 1990 to May 31, 1992
Pegasus Integrated Living Center	Erie, PA	July 1, 1990 to December 31, 1991
Progressive Living Units and Systems, Inc.	Southampton, PA	February 1, 1990 to September 30, 1991
ReMed Recovery Care Centers	Jenkintown, PA	July 1, 1990 to June 30, 1991

(Continued)

Provider	Location	Duration of Current Agreement
Tangram Rehab. Network, Inc.	San Marcos, TX	June 15, 1990 to December 31, 1991
United Cerebral Palsy of Central PA, Inc.	Belleville, PA	January 2, 1991 to June 30, 1992
United Cerebral Palsy Association of Pittsburgh District	Pittsburgh, PA	April 1, 1990 to September 30, 1991
Whitemarsh House, Inc.	Flourtown, PA	January 1, 1991 to December 31, 1991

Source: Developed by LB&FC staff from Department of Health Participating Provider Agreements with institutional service providers.

APPENDIX F. CASE MANAGERS AND CASE MANAGEMENT ORGANIZATIONS WITH A CURRENT PENNSYLVANIA HEAD INJURY PROGRAM PARTICIPATING PROVIDER AGREEMENT WITH THE DEPARTMENT OF HEALTH

Provider	Location	Duration of Current Agreement
Anderson Associates Psychology and Consulting	Harrisburg, PA	July 1, 1990 to June 30, 1993
Baker, Carol	Belleville, PA	August 1, 1990 to June 30, 1993
Crobak, Belinda	Shiresmantown, PA	August 1, 1990 to June 30, 1993
Fawber, Heidi	Zelienople, PA	August 1, 1990 to June 30, 1993
Longwood Rehab. Assoc.	Elizabethtown, PA	September 1, 1990 to June 30, 1993
Main Line Rehab. Associates, Inc.	Malvern, PA	April 1, 1990 to June 30, 1994
Millcreek and Erie County Advocates for the Developmentally Disabled, Inc.	Erie, PA	July 1, 1990 to June 30, 1993
O'Donnell, Bobbie	Dunmore, PA	July 1, 1990 to June 30, 1993
Orstein, Barbara	Mechanicsburg, PA	July 1, 1990 to June 30, 1993
Pollock, Robert	Pittsburgh, PA	August 1, 1990 to June 30, 1993
Team Rehab., Inc.	Kennett Square, PA	July 1, 1990 to June 30, 1993
United Cerebral Palsy of the Capital Area	Camp Hill, PA	July 1, 1990 to June 30, 1993

(Continued)

Provider	Location	Duration of Current Agreement
United Cerebral Palsy of Central Pennsylvania	Belleville, PA	July 1, 1990 to June 30, 1993
United Cerebral Palsy of Philadelphia and Vicinity	Philadelphia, PA	July 1, 1990 to June 30, 1993
United Cerebral Palsy of Pittsburgh Assoc.	Pittsburgh, PA	July 1, 1990 to June 30, 1993
United Cerebral Palsy of South Central PA, Inc.	Hanover, PA	July 1, 1990 to June 30, 1993
United Cerebral Palsy of Crawford, Venango and Clarion Counties, Inc.	Meadville, PA	July 1, 1990 to June 30, 1993
University Hospital Rehab. Center of the Pennsylvania State University	Elizabethtown, PA	July 1, 1990 to June 30, 1993
Van Solkema-Waitz, Terese	Bensalem, PA	July 1, 1990 to June 30, 1993
Vocational Rehab. Services, Inc.	Harrisburg, PA	May 1, 1990 to April 30, 1994

Source: Developed by LB&FC staff from Department of Health files.

APPENDIX G. INFORMATION ON SELECTED PROVISIONS OF CURRENT PHIP DRAFT REGULATIONS*

The current draft regulations:

- Set forth the rules governing the administration of the program and will describe the types of services available under the program.
- Define the eligibility criteria that must be met by applicants for services and the scope of services available to eligible applicants.
- Provide for an appeal mechanism which may be utilized by applicants dissatisfied with either services being provided or a determination by the Department as to eligibility.
- Emphasize the provision of case management services as an important service to be provided as soon as possible after the head injury. (According to the Department, rehabilitation services are designed to be part of the continuum of treatment with the goal of supporting an individual functioning in the community.)
- Make patients of traumatic head injury who are considered a threat to themselves or others and who require a 24-hour a day, structured, supervised living environment ineligible for program services.
- Establish a three-year funding limit for PHIP services from the date of initial eligibility determination and placement within an approved facility.
- Restrict eligibility to individuals who sustained head injuries on or after July 3, 1985, require that eligibility for services be limited to individuals who received head injuries while a resident (domiciled) of Pennsylvania, and require that the individual be residing within the state when services are being provided.
- Establish requirements for the development of a service plan for all eligible clients. (All "goal oriented providers and treatment facilities" are required by regulations to submit monthly status reports to the PHIP on the client's progress toward, or deviation from, specific goals identified within the service plan.)

(Continued)

- Require that the Department conduct a comprehensive, neurological evaluation for patients on a biannual basis to aid in determination of continued program eligibility or consideration for termination.

- Stipulate that quality assurance standards be established for the program.

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*/If adopted, these regulations will replace the interim policies under which the program has operated since 1988. This appendix lists key features of the proposed regulations. It is not intended as a comprehensive summary of the draft regulations.

Source: Developed by LB&FC staff from draft regulations and related Health Department materials.

APPENDIX H. ESTIMATED HEALTH-RELATED COSTS FOR A PERSON WITH A SEVERE HEAD INJURY (1988 DOLLARS)

1. Acute Medical Care
   a. Average Length of Stay - 60 to 90 Days
   b. Average Cost Per Diem - $2,000
   c. Total Cost (75 x $2,000) - $150,000
2. Acute Rehabilitation Costs
   a. Average Length of Stay - 90 to 120 Days
   b. Average Cost Per Diem - $550 to $600
   c. Total Cost (105 x $575) - $60,375
3. Extended Rehabilitation
   a. Average Length of Stay - 15 Months
   b. Average Cost Per Month - $13,000
   c. Total Cost (15 x $13,000) - $195,000
4. Residential Program for Remainder of Life (typical starting age range - 15 to 25 years of age)
   a. Average Duration - 30 to 60 Years
   b. Average Cost Per Year - $60,000 to $125,000
   c. Total Cost (45 x $92,500) - $4,162,500

Total Lifetime Care - $4,567,875

Source: The National Head Injury Foundation as cited in "Quality of Rehabilitative Care in Traumatic Brain Injury," PA Association of Rehabilitation Facilities.